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IN THE CIRCUIT COURT OF  
THE 11TH JUDICIAL CIRCUIT  
IN AND FOR DADE COUNTY, FLORIDA

GENERAL JURISDICTION DIVISION

CASE NO. 94-08273 CA (22)

HOWARD A. ENGLE, M.D.,  
et al.,

Plaintiffs,

vs.

R.J. REYNOLDS TOBACCO  
COMPANY, et al.,

Defendants.

\_\_\_\_\_ /

Miami-Dade County Courthouse  
Miami, Florida  
Thursday, 1:30 p.m.  
November 12, 1998

TRIAL - VOLUME 131

The above-styled cause came on for trial  
before the Honorable Robert Paul Kaye, Circuit Judge,  
pursuant to notice.

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APPEARANCES:

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SUSAN ROSENBLATT, ESQ.  
On behalf of Plaintiffs

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ROBERT C. HEIM, ESQ.  
SEAN P. WAJERT, ESQ.  
On behalf of Defendant Philip Morris

COLL DAVIDSON CARTER SMITH SALTER & BARKETT  
NORMAN A. COLL, ESQ.  
On behalf of Defendant Philip Morris

ZACK KOSNITZKY  
STEPHEN N. ZACK, ESQ.  
On behalf of Defendant Philip Morris

CARLTON FIELDS WARD EMMANUEL SMITH & CUTLER  
R. BENJAMINE REID, ESQ.  
On behalf of Defendant R.J. Reynolds

JONES, DAY, REAVIS & POGUE  
JAMES R. JOHNSON, ESQ.  
RICHARD M. KIRBY, ESQ.  
On behalf of Defendant R.J. Reynolds

KING & SPALDING  
MICHAEL RUSS, ESQ.  
RICHARD A. SCHNEIDER, ESQ.  
On behalf of Defendant Brown & Williamson

CLARKE SILVERGLATE WILLIAMS & MONTGOMERY  
KELLY ANNE LUTHER, ESQ.  
On behalf of Defendants Liggett Group  
and Brooke Group

SHOOK HARDY & BACON  
EDWARD A. MOSS, ESQ.  
WILLIAM P. GERAGHTY, ESQ.  
On behalf of Defendant Brown & Williamson  
JAMES T. NEWSOM, ESQ.  
On behalf of Defendant Lorillard

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APPEARANCES (Continued)

DEBEVOISE & PLIMPTON

ANNE COHEN, ESQ.

JOSEPH R. MOODHE, ESQ.

On behalf of Defendant The Council for Tobacco Research

GREENBERG TRAURIG HOFFMAN LIPOFF ROSEN & QUENTEL

DAVID L. ROSS, ESQ.

On behalf of Defendant Lorillard

MARTINEZ & GUTIERREZ

JOSE MARTINEZ, ESQ.

On behalf of Defendant Dosal Tobacco Corp.  
and Tobacco Institute

KASOWITZ BENSON TORRES & FRIEDMAN

AARON MARKS, ESQ.

On behalf of Defendants Liggett Group  
and Brooke Group

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1 (Whereupon, the following propositions were had:)

2 THE COURT: Have a seat, please.

3 What do you want to talk about?

4 MR. ROSENBLATT: There's one thing, Judge.

5 You'll remember that Dr. Steinfeld, when he was looking

6 at the letter from Peoples to Elliot Richardson, he

7 talked about backup documents. I've located the backup

8 documents, so I would -- they were admitted in Broin.

9 UNIDENTIFIED VOICE: That's what it says on  
10 the defendants' exhibit list.

11 MR. HEIM: I gather, Judge, what we'll do is  
12 mark them for identification and we can discuss them in  
13 one group.

14 THE COURT: I guess, yes.

15 MR. ROSENBLATT: I would like to have these  
16 marked as a composite to go along with the two letters  
17 that were earlier marked.

18 THE COURT: Okay. Do you want him to  
19 identify those?

20 MR. ROSENBLATT: Yes. He can do that outside  
21 the presence of the jury?

22 THE COURT: I don't care.

23 MR. KIRBY: Yes.

24 THE COURT: Anything else?

25 MR. HEIM: The only issue I had, Your Honor,

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1       was we deferred the issue about what Your Honor might  
2       say on preemption.

3               THE COURT:   Yes.

4               MR. HEIM:   And I took what we had proposed  
5       before and tried to simplify it.   Tried.   You will  
6       decide whether I simplified it or not.

7               But if I may, could I hand up to Your Honor  
8       what I wrote?

9               THE COURT:   Yes, sir.   I had looked at your  
10       first proposal the first time and --

11              MR. HEIM:   I thought it was a little long and  
12       complex.

13              THE COURT:   I declined to give it.   Let's put  
14       it this way.   Rather than dismiss it --

15              MR. HEIM:   Okay.   This is a much shorter  
16       version.

17              THE COURT:   Let's see how that differs, if  
18       any, from what I did say.

19              MR. ROSENBLATT:   Judge, you know, our  
20       position is that they objected to a part of an answer,  
21       and Your Honor agreed with their objection to the  
22       extent of deleting a part of Dr. Steinfeld's answer,  
23       and now we're opening a door and we are revisiting the  
24       whole issue of preemption.

25              Your Honor gave an instruction on the very

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1 first day; I think before I began my opening statement  
2 on October 19th. I believe you essentially rejected  
3 this.

4 But, in any event, we're really not here  
5 now -- we're dealing with things that don't need to be  
6 dealt with. They objected. Your Honor said you would  
7 instruct the jury to disregard a portion of an answer.  
8 There is no reason to be doing this now.

9 MR. HEIM: Your Honor --

10 MR. ROSENBLATT: And if Your Honor disagrees  
11 on that, Your Honor basically rejected this. There is  
12 no need to repeat now what you said on October 19th  
13 about preemption.

14 I mean, it's a wearing-down process. I don't  
15 think a sidebar goes by where someone does not mention  
16 the word "preemption." I know it's a big deal to them,  
17 but there's no need to instruct the jury -- I would  
18 like to have the jury instructed on a lot of things  
19 right now, but there's no need to instruct the jury on  
20 preemption now.

21 MR. HEIM: Well, Your Honor, counsel likes to  
22 refer to it as a big deal, but it is a federal law.

23 And there have been lots of preemption issues, that's  
24 true, and there have been discussions of preemption,  
25 and we have objected on preemption. This is a very

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1       simple, straightforward way of letting the jury know  
2       what this issue is so that they have some understanding  
3       of what the lawyers and the Court are doing.

4               THE COURT: I understand your position. I am  
5       somewhat concerned about the sentence regarding hiding  
6       or concealing, because it may look good at first  
7       glance, but there's too many "ifs," "ands" and "abouts"  
8       that are connected with that one phrase that need to be  
9       expanded, and you just can't leave it at that.

10              MR. HEIM: Well, Your Honor, I think if Your  
11       Honor is concerned about that sentence, Your Honor may  
12       decide not to recite that sentence.

13              But I believe it accurately sets forth the  
14       law.

15              THE COURT: Well, I don't know. I was  
16       reading -- what I did read -- in fact, I didn't tell  
17       him to read it. I just told him --

18              MR. ROSENBLATT: It almost seems -- if Your  
19       Honor were to read this or anything close to it, it  
20       almost seems that -- in the middle of the case,  
21       basically out of nowhere, from the jury's standpoint  
22       why is the Judge -- you know, it's not time for jury  
23       instructions.

24              THE COURT: I tell you, the only reason it  
25       could have been done would have been at the moment that

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1 the reference to preemption was made, which was the  
2 appropriate time to do it. And having it passed by,  
3 even though we did discuss it sidebar, they opted not  
4 to give that instruction at that time. Now I think  
5 we're beyond where we should be with it.

6 MR. MOSS: Well, what happened, Your Honor,  
7 if I may, is that you asked us, did you want to do it  
8 right then.

9 THE COURT: And you said no.

10 MR. MOSS: What we said was: Well, Your  
11 Honor, we would prefer that we give it. And we didn't  
12 have it, and you said: All right. We'll take it up  
13 later.

14 THE COURT: Yeah, but it's a little late. I  
15 thought you meant in a minute or two. I'm not happy  
16 with the statement you've made, basically.

17 MR. MOSS: You say you're unhappy with it?

18 THE COURT: I'm not happy with it, no.  
19 Doesn't thrill me.

20 MR. MOSS: But Your Honor --

21 THE COURT: I think we'll get to the  
22 instructions later on.

23 MR. MOSS: What we have right now then is a  
24 witness who testified about a matter that is preempted.

25 THE COURT: And I told them to disregard it.

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1       Okay.

2                   MR. MOSS: I don't think there was an  
3       instruction on that, Your Honor. I think you came back  
4       and we proceeded, and there was no instruction on that.  
5       But I'm not --

6                   THE COURT: We can find out?

7                   MR. MOSS: Yes, sir. But the point is that  
8       all of this has come up as a result of a question that  
9       was asked by plaintiffs' counsel, the answer to which  
10      was obvious.

11                  THE COURT: All right. I tell you, I really  
12      don't have any objection to reminding them again as to  
13      preemption, what it is, because it's coming up and it  
14      has come up before, and you keep standing up and  
15      saying: Objection, preemption.

16                  MR. MOSS: I can't help it.

17                  THE COURT: I will remind them of it. It's  
18      not going to hurt one way or the other, but I'll do it  
19      as I did before. And we can expand on any instruction  
20      on that at the end of the case when you can get into  
21      saying something more definitive about it. But for  
22      this purpose, we'll see that they know what we mean by  
23      preemption.

24                  All right. We'll bring the doctor up and  
25      resume his testimony. We're going to finish him today,

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1 I take it?

2 MR. ROSENBLATT: Oh, yes. As a matter of  
3 fact, the video people advised me, Judge, that they can  
4 be here at a quarter of 3:00. Obviously, if the doctor  
5 is still on the stand, we can go forward with the  
6 doctor.

7 THE COURT: Yes, but if it takes two hours  
8 and some odd minutes to run that tape --

9 MR. ROSENBLATT: They've done that basically,  
10 when they come here at a quarter of 3:00.

11 THE COURT: But we still have to go through  
12 some, talk about it.

13 MR. ROSENBLATT: I understand. Also, he  
14 would be in a position --

15 THE COURT: I understand that. But I'm  
16 talking about two hours, some odd minutes for the  
17 entire depo, and not that much is cut out. So it will  
18 take at least that kind of time to finish up that depo,  
19 which would run us past 5:00. I don't mind myself.  
20 I'm just telling you --

21 MR. ROSENBLATT: And by the way, I think we  
22 all have an understanding that we will not need the  
23 jury tomorrow.

24 THE COURT: Okay.

25 MR. ROSENBLATT: Right?

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1 THE COURT: So a workday tomorrow.

2 MR. HEIM: My understanding is that counsel  
3 would rather have a workday tomorrow. That's fine with  
4 us.

5 THE COURT: Okay.

6 MR. ROSENBLATT: What I would intend to do  
7 tomorrow is go over primarily the depositions. Because  
8 in terms of my witnesses next week, I have Dr. Douglas  
9 Johnson.

10 THE COURT: Johnson and Campbell?

11 MR. ROSENBLATT: And Farone live, and -- so  
12 tomorrow would be a day to go through the depositions,  
13 and also some of the video depositions of CEOs, if we  
14 can get to it.

15 MR. MOSS: Can you tell us what video  
16 depositions?

17 MR. ROSENBLATT: All the CEOs.

18 THE COURT: I don't have those. I have  
19 Campbell and Johnson, which I've gone through. Those  
20 are the only two I know of, other than the Tisch one.

21 MR. ROSENBLATT: Campbell, Johnston --  
22 there's a Johnston from American Tobacco. There's a  
23 Johnson --

24 THE COURT: I only did one.

25 MR. ROSENBLATT: Johnson from Reynolds.

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1 MR. SCHNEIDER: No. From American.

2 MR. ROSENBLATT: Then there's the other.

3 THE COURT: That's right. He was American.

4 MR. REID: Are there any live witnesses next  
5 week beyond those two?

6 MR. ROSENBLATT: As of now, no. Maybe by  
7 tomorrow.

8 THE COURT: We will work that out tomorrow.

9 MR. HEIM: So we're going to identify these  
10 documents, is that where we're going now?

11 THE COURT: Yes. The fact we talked about  
12 the backup, I will show you these.

13 Do you recognize what these are? Whatever he  
14 says? If you want to do it now, you can do it now.

15 MR. ROSENBLATT: Yes, I will do it right now.

16 VOIR DIRE EXAMINATION

17 BY MR. ROSENBLATT:

18 Q. Doctor, before the lunch break you had  
19 actually spoken about back-up documents in reference to  
20 the letter from Peoples of Reynolds to Elliot  
21 Richardson, the secretary of Health, Education and  
22 Welfare; and Richardson's response to Peoples. And you  
23 had mentioned certain back-up documentation.

24 I've handed you a composite exhibit for  
25 identification. Do you recognize those papers?

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1           A.    Yes.

2           Q.    What are they?

3           A.    They are the back-up papers.  That would  
4    indicate that Ray Cotton probably did author the one  
5    response.

6           Q.    Does seeing those back-up documents satisfy  
7    you 100 percent --

8           A.    Oh, yes.

9           Q.    -- that you saw the letter from Peoples to  
10   Richardson at that time?

11          A.    Oh, yes.  I can even recognize some of the  
12   words.

13          Q.    Some of the words are your words?

14          A.    Yes.

15          Q.    In the rough draft that you gave Richardson  
16   to respond to Peoples; is that correct?

17          A.    Yes.

18          Q.    Okay.

19               MR. ROSENBLATT:  Thank you, Doctor.

20               THE COURT:  We should do that in front of the  
21   jury.

22               MR. KIRBY:  Your Honor, could I just examine  
23   briefly to clarify the record?

24               THE COURT:  I guess.

25               MR. KIRBY:  May I approach, Your Honor?  It

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1 will make it go quicker.

2 VOIR DIRE EXAMINATION

3 BY MR. KIRBY:

4 Q. Dr. Staples (sic), Mr. Rosenblatt was kind  
5 enough to give me a copy of what he gave you. What I  
6 would like to do is attempt to clarify the record as to  
7 which of these are in fact the, as you called them,  
8 back-up documents.

9 Does your package contain an October 23, 1972  
10 letter?

11 You need to answer verbally.

12 A. Yes. Yes, it does. Sorry.

13 Q. That had previously been marked for  
14 identification. It bears Plaintiff's Exhibit for  
15 Identification 1894.

16 That's not a back-up document, is it; that's  
17 the letter itself?

18 THE COURT: Why are we wasting time on this?

19 MR. KIRBY: Because there's something in  
20 here, Your Honor, that's not a back-up document.

21 THE COURT: Fine. Get to it.

22 MR. KIRBY: I'm trying to separate the paper.

23 BY MR. KIRBY:

24 Q. Then there is also, Doctor, a group of  
25 documents stapled together bearing a November 10, '72

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1 date. And for identification purposes, there is a  
2 number on them unrelated to this case of 2587.  
3 Do you have those?  
4 A. Yes, uh-huh.  
5 Q. Is it that package that is, in your words,  
6 the back-up documents?  
7 A. Those are definitely back-up documents.  
8 Q. All right, sir.  
9 A. And then --  
10 Q. And then there is also this document, which  
11 appears to bear a date in August. Do you have it?  
12 A. Yes.  
13 Q. August 28, 1972?  
14 A. Uh-huh.  
15 Q. Which is before the October 23rd letter,  
16 correct?  
17 A. It should be.  
18 Q. And this document, the August 28, 1972  
19 document, is not therefore a back-up document for the  
20 response to the October 23rd letter, is it?  
21 A. No. It's not a back-up document. This one  
22 is a letter to Peoples from Elliot Richardson which I  
23 drafted, if you look at the bottom.  
24 Q. But it is not a back-up letter?  
25 A. No, but this isn't what I was shown to begin

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1       with.

2               MR. KIRBY: All right. Thank you very much.

3               THE COURT: Separate the one that you said is

4       not part of the back-up. Which one is it?

5               THE WITNESS: The first one.

6               MR. KIRBY: This is the back-up, Your Honor.

7               THE WITNESS: That is an earlier letter from

8       Richardson, which I wrote for him.

9               THE COURT: Okay.

10              THE WITNESS: And the back-up. (Handing)

11              THE COURT: So as far as the back-up packet,

12       is what's marked down here as 2587.01, 02, 03, 04, and

13       05 --

14              MR. KIRBY: I'm sorry, Your Honor. Where are

15       you?

16              THE COURT: I'm reading the numbers on the

17       bottom of the November 10th, 1972 back-up document.

18              MR. KIRBY: Yes, sir.

19              THE COURT: It also contains another letter

20       which is number 2587.06, two pages. And those will be

21       marked.

22              MR. KIRBY: Those others in your left hand,

23       Your Honor, have already been marked for

24       identification.

25              THE COURT: Those are the ones we marked.

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1       This one, 2587.07, two pages, should not be marked as  
2       part of that exhibit for identification at this time.  
3       I don't know what you want to do with it. So those  
4       are; this is not. All right.

5               MR. MOSS: Before you bring the jury in,  
6       could we have like 30 seconds to confer here?

7               THE COURT: Go.

8               (Plaintiff's Exhibit 11A was marked for  
9       identification.)

10              THE COURT: Did you get a report, by the way?

11              MR. ROSENBLATT: Yes. She's apparently --

12              THE COURT: Stable?

13              MR. ROSENBLATT: Yes.

14              MR. KIRBY: Your Honor, if you will bring the  
15       jury in, we're prepared that we have no questions.

16              THE COURT: No questions?

17              MR. KIRBY: No questions.

18              MR. ROSENBLATT: Well, then you'll have to  
19       send the jury right out, because the next thing I would  
20       have would be the video.

21              THE COURT: Well, we can do that. No  
22       problem. We will just have to do it. No problem.

23              Okay. Let's bring them out.

24              (The jurors entered the courtroom.)

25              THE COURT: Okay. Have a seat, folks.

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1           Before you get there, that composite, do you  
2       want to go through that composite with him while the  
3       jury is here, for identification?

4           (Sidebar off the record.)

5           THE COURT: All right. At this time,  
6       cross-examination.

7           MR. KIRBY: Dr. Steinfeld, the defendants  
8       have no questions. Thank you, sir.

9           THE WITNESS: Thank you.

10          THE COURT: Okay. At this time, then,  
11       Doctor, I think I can excuse you from any further  
12       service. That document you have in your hand, why  
13       don't you just drop it off.

14          THE WITNESS: I will. Thank you.

15          THE COURT: Appreciate it.

16          Okay, folks. We can announce at this time,  
17       however, that tomorrow is going to be a court workday.  
18       I told you I would let you know. You want to come in.

19          JUROR: No, that's okay.

20          JUROR: We like coming.

21          THE COURT: We were discussing it and we were  
22       hoping to get some testimony in tomorrow, but that  
23       doesn't seem to be the case. So we've got to play it  
24       by ear every time we do that.

25          And when we run into a problem, it's a good

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1       time for us to do what we have to do. For example,  
2       I've got to go take a look at one of these things that  
3       we have to go over. That's just one. There are lots  
4       of things.

5               So we have to do a lot of work together.

6       That's the time that we can find best to utilize for  
7       that purpose.

8               So for those of you who were wondering about  
9       tomorrow, we'll be off tomorrow. But we will work on  
10      Monday.

11              Now, with the turn of events that we've just  
12      witnessed here with no questions, that throws my whole  
13      schedule back a little bit, and the lawyers and I have  
14      got to do some work before we get to the next step.

15      But you are going to have to be here for that. So  
16      relax.

17              Let me ask you this question before we go.

18      Let me talk to the lawyers one second.

19              About how much time do you think it will take  
20      to go through this?

21              MR. HEIM: You mean the entire --

22              MR. ROSENBLATT: The video deposition.

23              THE COURT: Until we actually get to play it.  
24      We've got to go over some of the things with it.

25              MR. REID: 10, 15 minutes is all we need.

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1 THE COURT: I thought it was going to be  
2 extensive.

3 I would let you go to Burdines and spend some  
4 money.

5 JUROR: That would have been nice.

6 THE COURT: I knew I could count on one. But  
7 it's not going to be that extensive. If it was going  
8 to be a half hour or hour. But if it's only going to  
9 be a few minutes.

10 MR. REID: Judge, just one minute.

11 THE COURT: Maybe not.

12 (Sidebar off the record.)

13 THE COURT: That's what I thought. It's not  
14 going to be 15 minutes. It will be at least 45  
15 minutes, minimum. And it's just five to 2:00. See if  
16 you can get back here at quarter to 3:00. I'll let you  
17 roam about downtown, do what you have to do, spend  
18 money.

19 JUROR: It gets claustrophobic in there.

20 THE COURT: I understand. It is bad. You  
21 want to know something? That's the biggest jury room  
22 we've got. There are other jury rooms in this  
23 courthouse you wouldn't believe, where the jury, and  
24 there's only say six people in there, they sit facing  
25 in there and their knees touch.

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1 JUROR: Thank you. Then we appreciate the  
2 room.

3 THE COURT: So be thankful for what you've  
4 got.

5 All right, folks. Please don't discuss the  
6 case or do anything that you shouldn't be doing. Just  
7 come back at quarter of 3:00, if you would.

8 (The jurors exited the courtroom.)

9 THE COURT: You all may be seated.  
10 Let's go and see what we've got here. There  
11 are only about 13 of these that you've picked out?

12 MR. REID: Yes, sir.

13 THE COURT: Let's see what we're talking  
14 about.

15 MR. REID: Page 31 is the first one. I can  
16 tell you Number 1 and Number 7 covered the same subject  
17 matter. We ought to look at them separately, but ---

18 THE COURT: Well, let's see here. The  
19 question is, on Line 7: Again, what happens if  
20 somebody came to your office and said they were a  
21 smoker and you examined them, so forth, what  
22 recommendation would you make as to smoking?

23 What is the objection? Other folks have  
24 testified to that.

25 MR. REID: Once he goes into it, he starts

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1 discussing the hypothetical individual. There is no  
2 foundation about this person in the record. Individual  
3 claims aren't being tried in Phase I.

4 If you go to the next page, he talks some  
5 more about what he would do with individuals. You jump  
6 ahead, Your Honor, to the objection on 7.

7 THE COURT: What page?

8 MR. REID: Page 62. It's the same --

9 THE COURT: May be repetitious, but that's --

10 MR. REID: I think when you read them both  
11 you will see. He is talking about a particular patient  
12 that he had who came in, and he saw her in the  
13 emergency room.

14 THE COURT: That was a different story.  
15 Totally different. Let's stick with 31.

16 MR. REID: Okay. That's my basis on 31; that  
17 this is individual advice and doesn't have anything to  
18 do with the Phase I trial.

19 THE COURT: No. I think in relation to the  
20 testimony we've had so far, I will overrule that  
21 objection.

22 MR. REID: Number 2 is on Page 34. The next  
23 two -- it's about addiction.

24 THE COURT: Wait a minute. We have to tell  
25 the videographer what to do with it.

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1           MR. REID: I have the cites here. Any that  
2     you sustain, we will tell him he needs to cut these  
3     out.

4           THE COURT: Okay.

5           MR. REID: Page 34, Line 3 through 14. Line  
6     14.

7           THE COURT: Let's see. That's a completion  
8     of another answer. On Page 34, he's answering a  
9     question over an objection you had withdrawn.

10          MR. REID: Here's what happened. He asked  
11     him a question: What happens to your patients who quit  
12     smoking? Then he talks about it on Page 33. Then on  
13     the top of 34, beginning on Line 3, he goes to a  
14     different subject, which is, patients who don't quit  
15     smoking, which was not what was asked, so it's not  
16     responsive. I move to strike that response.

17          THE COURT: Let me find out. I have to go  
18     back to the question on: Have you had occasion to  
19     follow patients with a certain amount of heart disease  
20     and you recommended they stopped and they followed your  
21     recommendation, and in fact, did stop, and you  
22     continued to follow them?

23                 That question is relating only to smokers who  
24     did stop, okay.

25          MR. REID: Correct, and he answered that.

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1 THE COURT: The answer is fine down through  
2 Page 33 and 34, Line 2.

3 MR. REID: Yes, sir.

4 THE COURT: Then he gets into those who  
5 didn't stop.

6 MR. REID: That's my objection.

7 MR. ROSENBLATT: He just saved me a question.  
8 Witnesses have done that before all through the trials  
9 in terms of an answer. He's doing what is very  
10 natural, giving the other side of the coin. Obviously  
11 I would have asked him that question.

12 THE COURT: Yeah, I don't see any harm in  
13 that.

14 MR. REID: Your Honor, it becomes harmful  
15 when we get to the next one because he gets to  
16 addiction. That's the lead-in to addiction; people who  
17 were not able to quit.

18 When you get to the next one, you will  
19 understand that it becomes prejudicial because this  
20 witness says: I'm not an addiction expert, and yet he  
21 goes ahead and describes people as being addicted and  
22 people who can't quit even though they've been ill and  
23 so forth.

24 Your Honor, let me say, I did move to strike,  
25 and Mr. Rosenblatt had the opportunity. That's why you

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1       make those objections at the time, so he could have  
2       asked that other question, and he didn't.

3               So I would submit that those Lines 3 through  
4       14 ought to be stricken because they are clearly not  
5       responsive.

6               THE COURT: I don't think so. I don't think  
7       so.

8               MR. ROSENBLATT: And Judge, I would say,  
9       there's somewhat of a misconception, I think, going on  
10      here. There's no question. Dr. Grossman was not  
11      presented as a quote, unquote, "expert" on addiction in  
12      the sense that Dr. Benowitz was. But he is a hands-on  
13      clinician. He is the chief of cardiology at the  
14      University of California in San Francisco. He has had  
15      thousands of patients in his career. He is a  
16      clinician. He's brought on -- this has been his  
17      experience with his patients.

18              THE COURT: I overruled the objection.

19              MR. ROSENBLATT: But he's going --

20              THE COURT: Let's get there.

21              MR. ROSENBLATT: I'm sorry. I anticipated.

22              THE COURT: Where are we?

23              MR. REID: Your Honor, objections 3 and 4  
24      relate specifically to addiction.

25              THE COURT: Let's go to 39.

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1 MR. REID: 39, Line 24.  
2 THE COURT: Okay. Now, Line 24?  
3 MR. REID: In the middle of his answer --  
4 THE COURT: I didn't have that. There was no  
5 objection --  
6 MR. REID: Line 24 I said.  
7 THE COURT: Your objection comes on Page 40.  
8 Let me see --  
9 MR. REID: No, sir. Comes on Page 39, Line  
10 24, the first five words.  
11 THE COURT: No, not mine. Your objection is  
12 on Line 6: Let me object to the portion of that. Look  
13 at Page 40.  
14 MR. REID: That's when I made the objection.  
15 THE COURT: I know. Now I'm going back and  
16 finding out why.  
17 MR. REID: Okay.  
18 THE COURT: Are you with me on Page 40? He  
19 makes the objection on Line 6.  
20 MR. ROSENBLATT: Yes.  
21 THE COURT: And then I have to go back to the  
22 question and the answer. And he goes on to: A person  
23 who does all the wrong things but does not get serious  
24 heart disease, says I wish I knew the answer. Is there  
25 clearly a genetic vulnerability. Some people don't get

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1       addicted. Some people can eat steaks and eggs and  
2       bacon and their cholesterol stays fairly low. So there  
3       are mechanisms. That's an important subject for  
4       research.

5               I don't have any problem with that.

6               MR. REID: There's no problem, except the  
7       gratuitous comment: Some people don't get addicted.

8               He wasn't asked about that.

9               THE COURT: I don't have any problem with  
10      that.

11              MR. REID: If you look ahead, Your Honor, to  
12      Page 40.

13              THE COURT: I'm on Page 40.

14              Now, on the subject of tobacco addiction, on  
15      Line 10 --

16              MR. REID: Yes, sir. That's the next one.

17              THE COURT: Any opinion that you wish to  
18      express here today on that subject has been related to  
19      your own practice and your own hands-on patient care;  
20      is that correct?

21              And he objects. And the answer is: It  
22      certainly is correct. I'm not an expert on addiction  
23      from the point of view of prior research or having  
24      special addiction practices, but I'm a physician. I  
25      see patients taking medicines, certain habits, some are

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1       addicted to excess alcohol --

2               MR. REID:   Here is the problem I have with  
3       that, Your Honor.   As the Court is well aware, the  
4       Florida law says just because you are a physician  
5       doesn't mean you have expertise in all areas of  
6       medicine.

7               Number one, he wasn't identified or disclosed  
8       as an addiction expert.   The first reference to  
9       addiction was completely gratuitous.   It was something  
10      about mechanism of the injuries, had nothing to do with  
11      addiction.   He threw in the word "addiction."

12              After he did that and I objected, this  
13      question was asked.   He said based on his prior  
14      research or having special addiction practices, so he  
15      said:   I don't practice.   My hands-on practice isn't  
16      addiction, and I'm --

17              THE COURT:   Let me put it this way.

18              MR. REID:   And I haven't researched it and  
19      it's beyond the scope.

20              THE COURT:   There's a rose.   I know it's a  
21      rose.   I'm not an expert in roses, but I know it's a  
22      rose.   What kind of rose, I don't know; what causes it  
23      to be a rose, I don't know; what effect it has of being  
24      a rose, I don't know; but by God I know it's a rose.

25              Now, he can say what he believes he can

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1       determine from his own observation, and if he  
2       attributes that to a person as addicted to, that's not  
3       discussing it in terms of what an expert might discuss.

4               An expert wants to discuss the background of  
5       what addiction is, what it is not, how it formed, the  
6       effect of it, so forth. That's how an expert describes  
7       addiction. He's using addiction in the generic sense  
8       like you use addiction to chocolate or work. You are a  
9       workaholic and addicted to work or addicted to  
10       chocolate. That's how he's using this term. I think  
11       everybody recognizes that.

12               MR. REID: I think the problem with that,  
13       Your Honor, is respectfully when an expert -- a witness  
14       on the stand, who is presented and found to be an  
15       expert, uses words like this, where there's clearly an  
16       area of expertise that's been identified by plaintiffs  
17       in this case, and the jury has heard that there is a  
18       field that deals with the subject, and now they have a  
19       highly-qualified doctor who comes in and says: I don't  
20       practice this, I don't research it, but I'm going to  
21       give an opinion about it anyway, the jury can't make  
22       the determination between --

23               THE COURT: I think they can. I think that's  
24       all the function of a jury. They can look at this and  
25       say: Hogwash. You don't have any qualifications to

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1 say this is an addiction, so forth and so on.

2 He's saying: I look at people and I classify  
3 them as people who are addicted to smoking, alcohol,  
4 eating. What else do they mention here? Overeating  
5 and cigarette smoking, so forth. So I think in that  
6 context, in a generic context, and I understood it when  
7 I read it in that way.

8 MR. REID: I think clearly he makes it clear:  
9 I don't know anything about this as an expert.

10 THE COURT: I understand. If you get into  
11 why is a person addicted, what is addiction, how does  
12 it happen, so forth, so on, that's for the expert. I  
13 think under those -- in that context, I find nothing  
14 wrong with that.

15 MR. REID: Page 41, Line 15.

16 THE COURT: What is the official position of  
17 the American Heart Association?

18 MR. REID: Yes, sir. That's improper  
19 bolstering, asking him what the opinion is of some  
20 third party, an association that nobody is here from in  
21 this case.

22 THE COURT: I saw something on Page 4. He  
23 says on Line 18 he was at the annual scientific session  
24 of the American Heart Association. They hold a  
25 meeting. People come from all over the world. They

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1       had 45,000 physicians to hear the latest research.  
2       They had discussions, and that's where he gets his  
3       information.

4               MR. REID:   But he's relating -- it's hearsay  
5       in the basic form.   Somebody told him that at the  
6       meeting or he read it in some document.

7               But first and foremost, they're asking him to  
8       give the position of some other group, and it's an  
9       attempt to bolster, and it's inappropriate on direct  
10      exam to present a witness with the position of some  
11      group and say:   Is this consistent with what you  
12      believe?   Which is what they're doing.

13              And you'll see this throughout; that they  
14      continually say this is consistent.   All your friends  
15      at the Heart Association believe it, too?   This is the  
16      first time it happens.

17              MR. ROSENBLATT:   Judge, part of our theory  
18      here is that there is a consensus -- this has been gone  
19      into before -- who takes the position that the cause  
20      has not been scientifically proven other than the  
21      tobacco industry.

22              You look at Dr. Grossman's CV.   He's had a  
23      very long-standing -- I think he was president of the  
24      American Heart Association.   He's had a long-standing  
25      relationship with the American Heart Association.   He's

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1       been on their editorial boards. He is the chief --

2               THE COURT: Well, that's a different story.

3       If he's on the board --

4               MR. REID: He is not, Your Honor. He was  
5       involved with a local affiliate at one point. But he's  
6       not -- he's not being presented as an official of the  
7       American Heart Association to give the American Heart  
8       Association's view of anything.

9               He's bolstering his testimony with the views  
10       of third parties that he learned from hearsay or  
11       reading something that's not in court, and there is no  
12       way to cross-examine him about it. And you'll see  
13       later he says: I've talked to thousands of people.  
14       There is no way to cross him on that.

15              THE COURT: But he doesn't hold an official  
16       position?

17              MR. REID: No, sir.

18              MR. ROSENBLATT: But he did in the past.  
19       That's on his CV. I don't have the CV with me. But I  
20       covered this in the early questions. He is the chief  
21       of cardiology, University of California. He came from  
22       the American Heart Association meeting in Dallas to  
23       Miami to give his video deposition yesterday. He knows  
24       what the position is.

25              THE COURT: Yes. It's one thing to know;

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1       it's another thing to know in context of a legal  
2       process.

3               MR. ROSENBLATT: Yes, and the legal process,  
4       what we're trying to prove here is that -- and you've  
5       heard me ask that question to many witnesses, Judge:  
6       Is there any dispute? Is there any controversy --

7               THE COURT: Yes, but he didn't give that  
8       question in specific reference to an organization,  
9       which is what --

10              MR. ROSENBLATT: I've asked it -- it's come  
11       out in testimony before you, the position of the  
12       American Cancer Society, the position of some of these  
13       organizations, to show that there -- how else am I  
14       going to establish that there is -- there is no  
15       dispute? And I've asked --

16              THE COURT: The answer to that is you bring  
17       somebody in from the organization to express it.

18              MR. REID: That's right. Your Honor.

19              MR. ROSENBLATT: I think that someone who has  
20       a 30-year relationship with the American Heart  
21       Association and is so current that he just came from a  
22       meeting of the American Heart Association is entitled  
23       to say what is the position of that organization.

24              MR. REID: Just for the record --

25              MR. ROSENBLATT: It would be like the dean of

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1 a medical school: What is your -- it's like asking  
2 LeBow: What is your opinion? What is Liggett's  
3 position? It's the same.

4 MR. REID: Your Honor, let me say he hasn't  
5 been involved with the American Heart Association since  
6 apparently 1990, and he was not on any board. He was  
7 on various councils dealing with specific subjects over  
8 the years, program committee.

9 It's like being a member of the American Bar  
10 Association and being on the tort insurance practice  
11 group and somehow saying because you are on that, you  
12 can say what the position is of the parent  
13 organization.

14 He was involved with the Massachusetts  
15 affiliate back prior to '94, so council is wrong. He  
16 was not on the board and hasn't done anything in at  
17 least eight years. He went to that seminar out in  
18 Texas where there were thousands of doctors. He's  
19 bolstering his testimony with hearsay evidence.

20 THE COURT: It does, I think, come under the  
21 bolstering concept. I will sustain the objection.

22 MR. REID: 46 is the same testimony --

23 MR. ROSENBLATT: Wait a second. This is why  
24 we get messed up on the deposition. Let me understand  
25 what's being deleted so we can --

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1 THE COURT: All right. Page 41.

2 MR. ROSENBLATT: Page 41, what is deleted,  
3 Judge?

4 THE COURT: Line 15 through 25 on Page 41.

5 Now, on Page 43, all that colloquy of course  
6 is out on Page 42 and 43.

7 MR. REID: Yes, sir.

8 THE COURT: Then we get to Line 11. You  
9 again ask about the American Heart Association: Does  
10 the American College of Cardiology take the same or  
11 different position? You don't get the first question,  
12 you can't get the second.

13 MR. REID: Exactly. Same thing.

14 MR. ROSENBLATT: Let me say this, Judge, from  
15 a practical standpoint. Obviously this is totally  
16 discretionary with you. This is not a witness who was  
17 here. He was here, you know, yesterday. When I  
18 finished this deposition, I basically said to myself  
19 that I don't need another cardiologist. But, you know,  
20 he we want back to California and I really think  
21 that --

22 THE COURT: Look. I can't run your case for  
23 you and I can't tell you which witness to call. I can  
24 only tell you what the rules provide. You know as well  
25 as I do that the proper way of doing it, if you're

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1       going to get an organization's viewpoint or a policy,  
2       that you have to have somebody from that organization  
3       say it.

4               MR. ROSENBLATT: He is from an organization.

5               THE COURT: I'm talking about an official.

6               MR. ROSENBLATT: He is not a present  
7       official.

8               THE COURT: Well, that's a problem.

9               MR. REID: Your Honor, let me say for the  
10       record, starting on Page 41, Line 15, just so -- and  
11       now through Page 44, Line 7, takes care of the two  
12       objections plus all the colloquys that were  
13       interspersed.

14              THE COURT: Okay.

15              MR. ROSENBLATT: Let me see.

16              THE COURT: Yes.

17              MR. REID: All right. The next one is on  
18       Page 62, Line 7. This is the lady in the emergency  
19       room who had the heart attack.

20              THE COURT: Yes.

21              MR. REID: We object to describing this  
22       individual patient's condition. There is no way to  
23       know -- there is no way to cross-examine about her  
24       condition.

25              THE COURT: Oh, if you were talking about a

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1       condition that we're concerned with here, but we're  
2       not.

3               MR. ROSENBLATT: I think this is just -- is  
4       perfectly legitimate testimony. He's asked a question,  
5       and the whole concept cause, cause, cause. They're  
6       trying to make it very technical. The doctor is giving  
7       an example. He's saying: Look, I went into the  
8       emergency room. The husband had a heart attack. The  
9       wife was overwrought. She had a heart attack. I  
10      didn't do animal studies.

11             It totally fits. Not giving the name. He  
12      says: I know what caused this lady's heart attack:  
13      The stress of her husband's heart attack.

14             MR. REID: Your Honor, it's anecdotal  
15      hypothetical dealing with an individual patient that  
16      doesn't have anything to do with the claims in this  
17      particular case. The doctor gave an answer. He's  
18      talked about his views, but when he tries to bolster it  
19      with a case study --

20             THE COURT: It's not bolstering. When you  
21      look at the answer, I think there is an important  
22      distinction here between a scientific -- the conclusion  
23      that a physician makes based on his knowledge of  
24      individual patients. Then he goes on to give his  
25      knowledge. Anecdotal -- it's just an example of that.

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1 I don't see anything wrong with it. It's certainly not  
2 dispositive of any issue that we have here. I don't  
3 have any problem with it.

4 MR. REID: Now, the next one --

5 THE COURT: Wait. On Page 63, Mr. Rosenblatt  
6 makes some statement.

7 MR. REID: I'm assuming that's all out.

8 THE COURT: Don't assume unless we know.

9 MR. REID: I have a list of the colloquys I'm  
10 going to give to counsel. He represented this morning  
11 he told them to take it out.

12 THE COURT: It should be out.

13 MR. REID: I'll give it to him to make sure  
14 these are the ones he took out.

15 THE COURT: I don't have any problem with  
16 that. Now we're up to 95.

17 MR. REID: Yes, Your Honor. I'm not  
18 mentioning any colloquys because I'm assuming they're  
19 out.

20 THE COURT: Let's see. 95. Your objection  
21 was on 96. Let's see the objection. Question on 95,  
22 Line 11: Is it fair to say that in view of  
23 Dr. Braunwald, that as of now science has been unable  
24 to discover the risk factors associated with 50 percent  
25 of the aortic disease that exists in the world and he

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1       answers the question -- then there is a -- oh, I see.  
2       I will say that I worked for the doctor and he's  
3       brilliant. Is that what you're saying?  
4               MR. REID: That's the objectionable part.  
5               THE COURT: That he wasn't always right.  
6               MR. REID: That's right. Here is the problem  
7       with that. He has accepted him as an authority. When  
8       you get to the next page, you will find he worked for  
9       them. They've written articles together. He said he's  
10      brilliant.  
11              THE COURT: But he could be wrong.  
12              MR. REID: And then I read the quote. And  
13      then he said -- but he wasn't always right. He doesn't  
14      say he wasn't wrong about this quote. That's  
15      gratuitous. He wasn't always right. About what? It  
16      impugns the authority that he has just accepted as an  
17      authority, and in fact he said that he was his mentor,  
18      and he might --  
19              THE COURT: Do you want the whole picture or  
20      do we want only a portion?  
21              MR. REID: The point is he didn't say he was  
22      wrong about this quote.  
23              THE COURT: I look at this thing above me and  
24      say: Where did we go wrong if we can't find proof  
25      anymore?

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14399

1 MR. ROSENBLATT: He said he's brilliant.  
2 THE COURT: But sometimes he's wrong.  
3 MR. REID: I think the problem is the witness  
4 thought he was right this time.  
5 THE COURT: He didn't say that.  
6 MR. REID: That's my point. Didn't say he  
7 was wrong this time.  
8 THE COURT: I'm going to leave it the way it  
9 is.  
10 MR. REID: Next objection is the same  
11 objection. Now, Mr. Rosenblatt -- it's now repetitive  
12 actually.  
13 THE COURT: Same thing?  
14 MR. REID: Page 98, Lines 9 through 14. And  
15 I would ask the Court to exclude that now, because  
16 it's --  
17 THE COURT: Yes. It is repetitious. I read  
18 that. Yes, because the answer is the 50 percent, and  
19 did that on Page 95. So it is repeated.  
20 MR. ROSENBLATT: So on Page 96, what is out?  
21 MR. REID: Page 98, Lines 9 through 14.  
22 THE COURT: Wait a minute. I didn't say  
23 that.  
24 MR. REID: I'm sorry. That's where the  
25 objection was.

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14400

1 THE COURT: No. That's not where the  
2 objection was.

3 MR. REID: I didn't object to anything on 97.

4 THE COURT: On Page 97, Mr. Rosenblatt has an  
5 objection. It's repetitious.

6 MR. REID: I didn't think he was making my  
7 objections. I'm sorry.

8 THE COURT: He did, he did.

9 MR. REID: I know he did then, but --

10 THE COURT: And the repetitious nature of his  
11 question and answer, it was the risk factor being  
12 associated with half the coronary artery disease cases.  
13 Two pages prior he said something about 50 percent of  
14 the arteries, so that's the repetitious part of that.  
15 50 percent or half to me is the same. So I sustained  
16 the objection.

17 MR. REID: Okay. I understand what you're  
18 saying.

19 MR. ROSENBLATT: So what's out?

20 THE COURT: So the question or the -- I  
21 think --

22 MR. REID: I didn't understand that  
23 Mr. Rosenblatt was asking that that objection be  
24 granted today.

25 THE COURT: Page 96, Line 23 through 25, and

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14401

1       97, Line 1 through 4 --

2               MR. REID: Yes, sir.

3               THE COURT: -- are excluded, along with the

4       colloquy.

5               Okay. Now we get to Page --

6               MR. REID: 98, Line 9.

7               THE COURT: You didn't make an objection.

8       There is no objection.

9               MR. REID: Well, it's not to the form. Now

10       it's become, because of your first ruling, it's become

11       repetitious. It wasn't at the time. There was no

12       reason to do it. But now that you ruled, it's going to

13       come in the first time. Mr. Rosenblatt did this

14       because he wasn't satisfied with the way it was said

15       the first time. This is a repeating, saying he's a

16       brilliant man, but he might be wrong -- or was right.

17       Wasn't always right.

18               THE COURT: He's entitled to do that.

19               MR. REID: Now I'm saying it's completely

20       repetitive because of your previous ruling. They're

21       going to hear that same sentence twice.

22               THE COURT: No. I disagree with that. Now

23       you are redirect, different person asking questions.

24       It's like rehabilitation.

25               Okay. Page 102.

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14402

1 MR. REID: 101.

2 THE COURT: 101, I'm sorry. I didn't have --  
3 well, the objection is on the top of 102.

4 MR. REID: Yes, sir.

5 THE COURT: I object to the last three  
6 questions. And move to strike the answer. So I go  
7 back three questions. And the question starts on Page  
8 101, Line 11. And the question is: And why that is,  
9 speaking scientifically, is somewhat of a mystery I  
10 suppose.

11 So I have to go back to the question before  
12 that. Question on Line 5.

13 MR. ROSENBLATT: I refer to a question that  
14 was asked on cross.

15 THE COURT: Let me just see. Counsel made a  
16 point that whatever percentage some people get heart  
17 disease, that's the 50 percent factor, and you are  
18 getting into a different aspect of that. That's fine.  
19 Good question. The answer is okay.

20 Next question: And why is that?  
21 Scientifically, is it a mystery? He said yes.

22 Question: But the issue of whether cigarette  
23 smoking causes heart disease, is that a mystery? He  
24 said not to me.

25 Is it a mystery to the American Heart

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14403

1 Association? That's what you're talking about?

2 MR. REID: Yes, sir. The handwritten  
3 objections I gave you with respect to that is the only  
4 part we are objecting to.

5 THE COURT: Line 18.

6 MR. REID: Line 18, where now he's talking  
7 about it's a mystery to the American Heart Association.  
8 18 through 25.

9 THE COURT: Yes. Well, I have to be  
10 consistent with that one then.

11 MR. REID: Actually, for the record, it's  
12 Page 101, Line 18 through Page 102 Line 3, which covers  
13 the colloquy.

14 THE COURT: Yes.

15 Let me see what else. Very esoteric about  
16 this stuff. 102, Line 5, the objection is there.

17 MR. REID: Yes, sir. This is similar to the  
18 American Heart. He was asking about all these other  
19 cardiologists, other people in medicine, he's talked to  
20 constantly from all over the country, all over the  
21 world. Based on hearsay, that's bolstering.

22 THE COURT: That's a result to a question,  
23 whether there's any controversy in the medical  
24 community or scientific community.

25 MR. ROSENBLATT: Exactly.

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14404

1           MR. REID: I didn't ask him that question, I  
2     don't think.

3           THE COURT: Well, that goes to the previous  
4     statement. That's the problem with it.

5           MR. REID: To counsel's previous questions, I  
6     agree.

7           THE COURT: I think you could pick it up  
8     starting with the Line 7, Page 102. I think you could  
9     just pick it up at the word: I just want to have an  
10    understanding.

11          If you just give that part of the question  
12    and the answer, I have no problem with that.

13          MR. ROSENBLATT: So the first three lines,  
14    Lines 5, 6, 7, with the exception of the word "I," are  
15    out.

16          THE COURT: Or you can start with Line 8:  
17    Just to have an understanding.

18          MR. ROSENBLATT: Yes.

19          MR. REID: Your Honor, based on that, if you  
20    look at the beginning, Line 23, where he talks about he  
21    doesn't recall anybody ever coming up to him and  
22    saying --

23          THE COURT: Yes, I read it.

24          MR. REID: I will ask you to remove that  
25    part.

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14405

1 THE COURT: I'm not going to remove it.

2 MR. REID: What you would be removing would

3 be --

4 THE COURT: 102, I'm removing Line 5, 6, 7.

5 MR. REID: Okay.

6 THE COURT: Now to 106. One of these days  
7 I'm going to understand what is meant by "objection as  
8 to form." One of these days I'm going to understand  
9 that. I haven't got the foggiest idea what that means,  
10 because it's such a broad, open area.

11 MR. ROSENBLATT: And as always, the people  
12 that came up with that objection thought they were  
13 greatly simplifying. It's always that way. The  
14 attempt to simplify.

15 THE COURT: And the problem is that what you  
16 could -- if they had said at a deposition: Objection,  
17 hearsay, relevance and materiality, blah blah blah, I  
18 would know what we're talking about. When I see  
19 "objection as to form," I look at it, what is the  
20 syntax "wrong"? Left out a word? What are we talking  
21 about? You have to go behind somebody's thought  
22 process.

23 MR. HEIM: Some of them you know, like  
24 compound questions.

25 THE COURT: And you say so. Maybe they

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14406

1       taught me in law school a lot differently. Make an  
2       objection, state your reason. But this business of  
3       form doesn't make any sense. Makes it so much more  
4       difficult. Why are you making this objection? I have  
5       to start thinking.

6               MR. REID: On the other hand, there is a  
7       concern about speaking objections.

8               THE COURT: There is no speaking objection  
9       basically.

10              MR. REID: There's not, but some lawyers get  
11       carried away.

12              THE COURT: This is why the rule is you make  
13       an objection, say one word. That's the end of it. We  
14       know what we're talking about. Why? Now, if you want  
15       me to start lecturing lawyers about how to do depositions --

16              MR. REID: No.

17              THE COURT: I don't want to do that here.

18              MR. REID: I was trying to keep the tape as  
19       clean as possible so we wouldn't have this problem.

20              THE COURT: I'm not faulting you. You're  
21       doing what the rules provide. I'm not faulting you. I  
22       don't have to agree with the rules.

23              MR. REID: No.

24              THE COURT: Now you're saying: What is wrong  
25       with the question?

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14407

1           MR. REID: 106, it's multiple, compound, and  
2       now it's repetitive. This is going back and having him  
3       explain again about the lady in his office who had the  
4       heart attack. And it's leading.

5           THE COURT: Well, it doesn't answer the  
6       question.

7           MR. ROSENBLATT: Counsel had read part of  
8       this question, Judge, in his cross, this very question.  
9       And I completed the question.

10          THE COURT: But wait a minute. Doesn't  
11       answer the question on Page 106, Line 2. Oh, he does.  
12       I'm sorry. There is an answer. Yes.

13          MR. REID: Line 15 is where my objection --  
14       Line 15 is where my objection begins.

15          THE COURT: No.

16          MR. REID: On the paper I handed you this  
17       morning, that's the part I'm --

18          THE COURT: I love the way you make an  
19       objection before the thing is answered. The way it  
20       reads, 106, Line 2 is a question. There is an answer  
21       on Line 10. Then you object. And you object to the  
22       form of that question and move to strike that answer.

23          MR. REID: Yes, sir.

24          THE COURT: And then Mr. Rosenblatt comes  
25       back and does something else, and he says: Let me ask

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14408

1       you this question.

2               MR. REID:   And just so the Court understands  
3       what I'm doing --

4               THE COURT:   Now you have an objection on Line  
5       4 on Page 107.   That's the objection you're talking  
6       about?

7               MR. REID:   Yes, sir.   I think the problem I'm  
8       having, Judge, when you say I have an objection, I've  
9       been citing the place that's objectionable.   And you  
10      are looking at where I object.

11              THE COURT:   I have no idea what you're  
12      pointing to.

13              MR. REID:   I try to make it clear by writing  
14      it out.   That's what we're doing.   I'm withdrawing --

15              THE COURT:   You're withdrawing the first one  
16      on Page 106 and talking about 107.   That's fine.

17              Now you want to talk about the question on  
18      Line 15.   Overrule the objection.

19              Okay now.   Where are we?   Page 109.   Let's  
20      see where we're talking about.   The objection is on  
21      Page 110, is that it?

22              MR. REID:   Actually, on 109.

23              THE COURT:   Okay.   Now I've got three of them  
24      on that page.   Which one are you talking about?

25              MR. REID:   The question starts on Line 4.

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1 THE COURT: Question, Line 4.

2 MR. REID: That's the American Heart  
3 Association, so forth.

4 THE COURT: Yes. I'll sustain that.

5 MR. REID: Then the next question is also  
6 objected to, where he quotes me: Gee, there is a lot  
7 of science missing, quote. I don't remember saying  
8 "gee."

9 MR. ROSENBLATT: I say: Counsel seems to  
10 say --

11 THE COURT: Okay. So there is a lot of  
12 science missing. I don't want to know why all your  
13 scientists are perfectly comfortable using the concept  
14 of causation.

15 MR. ROSENBLATT: That's what the question is  
16 about.

17 MR. REID: That's the question, is all the  
18 other scientists, not himself.

19 THE COURT: Generic.

20 MR. REID: Yes, sir. That's objectionable.

21 THE COURT: The heart attack.

22 We're not talking about smoking; we're  
23 talking about heart attack. Oh, cigarettes, what  
24 causes coronary heart disease and heart attacks. We  
25 cut that out. So now what are you talking about?

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14410

1           MR. ROSENBLATT: Is that cigarette smoking is  
2   a direct cause of --

3           THE COURT: Here it is, Page 110.

4           MR. ROSENBLATT: 110.

5           MR. REID: It's really a speech at the end,  
6   Your Honor. It's not a response to a question.

7           THE COURT: I don't have a problem with that.  
8   Overrule the objection. No.

9           MR. REID: All right. Our last point on  
10   this, Your Honor, I would like to make is that -- is a  
11   general position on this particular witness. With this  
12   witness, this will be the ninth witness that's giving  
13   testimony about heart disease as relates to smoking.  
14   Dr. -- well, virtually every witness.

15          THE COURT: Why don't you tell me that  
16   before? We didn't have to go through this exercise.

17          MR. REID: Well, I apologize. And I think  
18   the Court will remember Dr. Staples particularly, who  
19   brought part of a heart in and showed the jury. He was  
20   lung and heart and he talked about the surgery and the  
21   problems that happen to the --

22          THE COURT: What is his specialty here?

23          MR. REID: This man is a heart --

24          MR. ROSENBLATT: This is the only  
25   board-certified cardiologist that we have had. One.

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1 We are entitled to two. This is the only one we've  
2 had. It's true that doctors in internal medicine and  
3 surgeons -- this is the only board-certified  
4 cardiologist, and we limited him to disease -- heart  
5 diseases caused by cigarette smoking.

6 MR. REID: Your Honor, the problem we have is  
7 while everybody was entitled to identify two experts in  
8 a field, it doesn't mean that you are permitted to put  
9 on cumulative testimony. And counsel didn't have to  
10 ask. And in other words, we would object as we went  
11 along to certain doctors, Dr. Petty for instance,  
12 whether he should have been permitted to give heart  
13 testimony.

14 THE COURT: Well, that was peripheral.

15 MR. REID: Being outside his area.

16 THE COURT: That was peripheral. This whole  
17 thing is geared toward heart.

18 MR. REID: You have Dr. Richmond, Davis,  
19 Staples, the other Davis, Petty, Burns, Samet.

20 THE COURT: They didn't talk specifically  
21 about that.

22 MR. REID: They talked about a lot of  
23 diseases, but Dr. Staples clearly did talk about a  
24 heart. He showed them a heart, how it worked. Showed  
25 them about the arteries being clogged. He was showing

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1       them what this witness is testifying to. It becomes  
2       cumulative at some point.

3               THE COURT: All right. You made your  
4       objection on the record. I will overrule the  
5       objection.

6               Where is the videographer?

7               THE BAILIFF: He is outside.

8               THE COURT: How long is it going to take to  
9       go through this?

10              MR. ROSENBLATT: He can cut it -- I think he  
11       can press a button.

12              THE COURT: We have 15 minutes anyway between  
13       now and the time the jury gets back.

14              (A brief recess was taken.)

15              MR. REID: Judge, we have one thing to ask  
16       about. During the deposition, as I did with the  
17       witness the other week, I put this up on the board as  
18       if he were live. I want to put these up on the board  
19       at the appropriate time during cross.

20              THE COURT: Okay. Sure.

21              Why don't you turn that monitor on the top so  
22       they can see it. I don't need to see it.

23              (The jurors entered the courtroom.)

24              THE COURT: Okay. I think everybody is here.  
25       All right, folks. Have a seat.

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14413

1           We are going to be watching now on videotape  
2   the testimony of William Grossman, MD. This kind of  
3   testimony is very much the same as when we are reading  
4   deposition testimony to you.

5           When we talk about a deposition, a statement  
6   taken prior to trial, under oath, the same applies to  
7   this kind of testimony. The rules provide that under  
8   certain circumstances, the testimony of a witness may  
9   be taken prior to trial, to be shown to a jury during  
10   trial, if that witness is otherwise unavailable to come  
11   into court and sit in this chair and testify.

12           So the testimony you are about to see will be  
13   just as if this witness was here with us live, but it  
14   will be on videotape.

15           The attorneys had an opportunity to be  
16   present when the video was being taken, and to make any  
17   objections they thought were appropriate at the time,  
18   and that's preserved in a transcript, which we've been  
19   taking the time since you were out at Burdines, and  
20   ruling and going through some of the objections.

21           You will find that during the course of the  
22   presentation of the testimony, some of the objections  
23   will be heard by you. You'll hear such a word as  
24   "objection as to form" or something of that nature, and  
25   then along throughout the course of the pr     lii\_

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1       there may be some gaps in the audio part of the  
2       testimony.

3               And the reason for that is a ruling was made  
4       as to the objection, and the video technician will turn  
5       the sound down. I believe that's what you will do.  
6       And you won't hear the answer to the question. You may  
7       see the talking head, but you won't hear the answer.

8               Don't read his lips. Okay? I don't know if  
9       any of you can. If we wanted you to hear it, we would  
10       let you hear it.

11              That's the way the rules go. So I wanted to  
12       explain that to you as we proceed. There is no  
13       reflection on either side that all of that wasn't cut  
14       out before, but we just had to wait until I got the  
15       full transcript and we discussed it as to the various  
16       objections. That's where we're at at this time.

17              So accept the testimony that you hear and see  
18       on this video just as you would had that person been  
19       here live, as we've been doing the last week or two.

20              All right. And it runs about two hours.  
21       Just want to let you know that in advance. Okay.

22              MR. ROSENBLATT: And Judge, this video of  
23       Dr. Grossman was done yesterday in Miami. Because you  
24       had talked generally about testimony before trial.  
25       This was done yesterday.

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14415

1 THE COURT: I forgot about that. You're  
2 correct. He came down here. Court wasn't in session,  
3 and it was the only day he had. So we had to videotape  
4 it.

5 So be that as it may. It happened prior to  
6 the time of his testimony. Makes no difference one way  
7 or the other.

8 Yes, sir. Go ahead.

9 (The videotape commenced.)

10 MR. ROSENBLATT: Stanley Rosenblatt on behalf  
11 of the plaintiffs.

12 MR. REID: Ben Reid on behalf of Reynolds  
13 Tobacco Company.

14 MR. GERAGHTY: Bill Geraghty on behalf of  
15 Brown & Williamson.

16 MR. ZACK: Steve Zack on behalf of Philip  
17 Morris.

18 MS. LUTHER: Kelly Luther on behalf of  
19 Liggett and Brooke Group.

20 Thereupon:

21 WILLIAM GROSSMAN, M.D.  
22 having been called as a witness, was duly sworn,  
23 examined, and testified as follows:

24 DIRECT EXAMINATION

25 BY MR. ROSENBLATT:

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14416

1           Q.    Good morning, Dr. Grossman.  For the record,  
2    please tell the members of the jury your full name and  
3    your present professional address.

4           A.    My name is Dr. William Grossman.  My address  
5    is University of California, San Francisco.

6           Q.    You are a medical doctor specializing in the  
7    field of cardiology; is that correct?

8           A.    That's correct.

9           Q.    And your present position is you are chief of  
10   cardiology at the University of California San  
11   Francisco Medical Center; is that correct?

12          A.    That's right.  That's correct.

13          Q.    Okay.  I wanted to establish your present  
14   position before I take you through your curriculum  
15   vitae and go over your medical education, background  
16   and training.

17                You know, before I do that, you came in today  
18   from Dallas.  You traveled from Dallas to Miami today  
19   on November 11; is that correct?

20          A.    Yes.

21          Q.    What were you doing in Dallas?

22          A.    I was at the annual scientific sessions of  
23   the American Heart Association.  Every year the  
24   American Heart Association holds a meeting in November.  
25   Physicians come from all over the world.  I think this

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14417

1       year we had 45,000 physicians from the United States,  
2       Europe, Asia, to hear the latest in research on heart  
3       disease, to hear discussion, debates, controversies.  
4       That's where I was.

5             Q.     How long did the convention last this year?

6             A.     The official dates are from Sunday morning  
7       until Wednesday afternoon.

8             I was scheduled to stay there until the end  
9       of the meeting today, but I canceled to come here and  
10      make myself available for this testimony.

11            Q.     You would have been available to testify live  
12      and in front of the jury today, but as it turned out,  
13      it's Veterans' Day. It's a court holiday and the  
14      courthouse is closed. So obviously we're taking your  
15      testimony by way of video as a substitute.

16            And you're leaving today, later today, to go  
17      back to California?

18            A.     Yes.

19            Q.     Okay. Now, you went to undergraduate school  
20      at Columbia University. What year did you graduate  
21      Columbia?

22            A.     1961.

23            Q.     And what was your major?

24            A.     I majored in biological sciences.

25            Q.     Where did you get your medical doctor degree

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1 and what year?

2 A. I received my MD degree from Yale University  
3 in 1965.

4 Q. Now, I notice in looking at your curriculum  
5 vitae it shows that you got an MA degree from Harvard  
6 University?

7 A. That's correct.

8 Q. What is the MA?

9 A. It's a Master of Arts degree, but it was  
10 received honoris causa, which means it is honorary  
11 degree that I received from Harvard.

12 Q. And after you graduated from the Yale  
13 University School of Medicine in 1965, you served an  
14 internship at Peter Bent Brigham Hospital in Boston; is  
15 that correct?

16 A. Yes.

17 Q. And what connection, if any, does Peter Bent  
18 Brigham Hospital in Boston have to the Harvard  
19 University Medical School?

20 A. The Brigham Hospital, as it's called, is a  
21 major teaching affiliate of Harvard Medical School.

22 Q. Then following your internship, as I'm going  
23 down your curriculum vitae, you were a Peace Corps  
24 physician in New Dehli, India from 1966 through 1968.

25 Tell us, if you would, in a general way, what

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1       you were involved in in that role.

2           A.     Well, my wife and I had -- when we got  
3       married in '64, had determined that we were going to go  
4       to the Peace Corps for two years. We were both very  
5       inspired by Kennedy, and so we applied to go after my  
6       internship, and we went in July of 1966.

7           My work in India consisted of both having a  
8       clinic, taking care of sick patients, Indian patients,  
9       and also participating in their family planning effort  
10      for two states in India, the states of Punjab and  
11      Haryana.

12          Q.     And after you returned to the United States  
13      from India, I see you went back to Peter Bent Brigham  
14      Hospital in Boston this time to do your residency?

15          A.     That's correct.

16          Q.     And what was the focus of the two-year  
17      residency at the Peter Brent Brigham Hospital?

18          A.     The residency completed my training in  
19      internal medicine and was preparatory for my training  
20      in cardiology. I continued on at the same hospital for  
21      training in cardiology, completing it in 1971.

22          Q.     Okay. Yeah, I see after you completed your  
23      residency, you became a research fellow in medicine,  
24      the specialty of cardiology.

25                 So is it fair to -- at what point in time had

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1       you made the decision that you were going to specialize  
2       in cardiology as opposed to being more general in  
3       internal medicine?

4           A.     During my internship I made that decision.

5           Q.     And after you completed your research  
6       fellowship, I see you became an assistant professor of  
7       medicine at the University of North Carolina School of  
8       Medicine in Chapel Hill, North Carolina, and then you  
9       became an associate professor of medicine at the  
10      University of North Carolina School of Medicine.

11           Tell us, other than the teaching  
12      responsibilities at the University of North Carolina  
13      School of Medicine, what else did you do there  
14      professionally?

15           A.     My primary professional responsibility at the  
16      University of North Carolina was to serve as director  
17      of the cardiac catheterization laboratory at North  
18      Carolina Memorial Hospital, and in that capacity, I  
19      performed many cardiac catheterization and cardiac  
20      angiogram tests on patients who were referred into the  
21      hospital for evaluation of heart disease.

22           Q.     Now, I think most people have heard the word  
23      heart catheterization, but I think relatively few  
24      really understand precisely what that entails.

25                   So the cardiac catheterization laboratory,

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1       what is the purpose of the catheterization, and tell us  
2       about the procedure itself.

3           A.    Most people know about coronary angiography,  
4       about angioplasty, and all the modern treatments for  
5       coronary heart disease that involve putting catheters  
6       back inside the heart.

7           These are all done in the cardiac  
8       catheterization laboratory where thin, long plastic  
9       tubes called catheters are inserted either into an  
10      artery in the groin or in the arm and passed back into  
11      the heart where they are used to measure pressure, and  
12      then to do an angiogram, where we inject an X-ray dye  
13      into the blood vessels feeding the heart muscle, the  
14      coronary arteries, and we can see whether there are  
15      blockages in the coronary arteries.

16           Nowadays we usually proceed right then and  
17      there to open those blockages, either with a balloon  
18      angioplasty or the placement of a stent, which is a  
19      metal scaffolding device that we expand in the artery.

20           So I chose early on to specialize in that  
21      subject, and in fact, in Chapel Hill I wrote the first  
22      edition of my textbook, Cardiac Catheterization,  
23      Angiography and Intervention, which is now in its fifth  
24      edition.

25           Q.    And that's a book that's used in medical

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1 schools throughout the country?

2 A. Yes. Actually it's translated into about  
3 five languages. It's used throughout the world.

4 Q. What is the significance from a practical  
5 standpoint of these blockages?

6 In other words, you do the heart  
7 catheterization, you look at the arteries, you see  
8 there's blockage. What is the significance of that?

9 A. That's -- I would say that finding these  
10 blockages and fixing them is the primary reason that  
11 cardiac catheterization is done today throughout the  
12 world. And the blockages impede blood flow. They  
13 prevent normal coronary blood flow to the heart.

14 Your heart muscle needs to have a steady and  
15 continuous source of blood and oxygen if it's going to  
16 work. Unlike our skeletal muscles, our heart has to  
17 work every minute, 24 hours a day, and so it needs --

18 Q. It doesn't get any days off, no holidays?

19 A. No holidays. So it needs an unimpeded supply  
20 of blood and oxygen-rich blood.

21 Now, when there are blockages in the coronary  
22 arteries, they will block the delivery of oxygen, and  
23 patients will start to either get angina, which is an  
24 aching or pain in the chest, or if the blockage is more  
25 extensive, they may actually go on to have a heart

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1     attack.

2             Q.     And then while we're on the subject of the  
3     heart itself receiving blood and oxygen, and then does  
4     it become -- is it the function of the heart to then  
5     pump blood and oxygen to other organs of the body?

6             A.     Yes.   The heart bumps blood to all the organs  
7     of the body, so if your heart isn't pumping  
8     effectively, you develop first heart failure where  
9     blood will back up into the lungs and cause shortness  
10    of breath, and eventually you will develop stroke,  
11    shock, other conditions due to poor delivery of oxygen  
12    to the rest of the body.

13            Q.     And I see, Doctor, in looking at your  
14    curriculum vitae, after you served in that position at  
15    the University of North Carolina School of Medicine,  
16    you became the director of the cardiac catheterization  
17    laboratory at Peter Bent Brigham Hospital, and you also  
18    became a professor of medicine at the Harvard Medical  
19    School.

20            Were you doing essentially the same work at  
21    the hospital in Boston as you had done in North  
22    Carolina?

23            A.     Yes.   My old professor at Harvard retired,  
24    and they asked me to come back and take over his  
25    position.   So that's why we left North Carolina, which

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1 I enjoyed being there greatly, but this was a good  
2 professional opportunity for me.

3 Q. Well, in a sense it was returning home,  
4 because you had done your internship and residency and  
5 fellowship at Peter Bent Brigham Hospital?

6 A. Yes.

7 Q. So you are certainly familiar with Boston and  
8 the Harvard Medical School, correct?

9 A. Correct.

10 Q. I see in looking at your CV, that it lists  
11 that from 1975 through 1980, you were an established  
12 investigator at the American Heart Association.

13 What does that mean?

14 A. The American Heart Association gives a  
15 certain number of awards each year to support the  
16 career of individuals who are doing research into the  
17 causes and correction and treatment of heart disease,  
18 and I was chosen as one of these investigators, and  
19 basically that meant that the American Heart  
20 Association provided support for 75 percent of my  
21 salary during those five years, freeing me up to spend  
22 a significant amount of my time doing research at that  
23 time on heart disease.

24 Q. Now, apparently, if I'm reading this  
25 correctly, you left as director of the cardiac

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1 catheterization laboratory at Peter Bent Brigham  
2 Hospital, and then you went -- you became chief,  
3 cardiovascular division at Beth Israel Hospital, Dana  
4 professor of medicine at the Harvard Medical School in  
5 Boston.

6 Tell us what your role was as chief of the  
7 cardiovascular division at Beth Israel hospital.

8 A. As chief of cardiology, I oversaw all the  
9 areas of cardiology, not just the cardiac  
10 catheterization laboratory, but the coronary care unit,  
11 the echocardiography laboratory, the arrhythmia group,  
12 and also was able to build a large group of researchers  
13 who were working in basic science investigation.

14 Q. Now, you were the chief of the cardiovascular  
15 division. Can you estimate for us the number of other  
16 doctors who were in that division as well?

17 A. When I joined that division as chief in 1981,  
18 there were six cardiologists. When I finished my term  
19 there, we had 28 faculty, and we had 50 trainees in  
20 cardiology as well.

21 Q. And how does that -- those numbers compare  
22 with your present position as chief of cardiology at  
23 the University of California San Francisco Medical  
24 Center? How many doctors, how many faculty members?

25 A. The University of California system is even

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1       larger than that. So we have 28 physicians and  
2       scientists in our direct hospitals, and another 25 in  
3       our affiliated programs.

4           Q. Now, there's a section of your CV called  
5       Memberships, and I'm just going to ask you about some  
6       of the organizations of which you are a member.

7                   The American Heart Association Councils on  
8       Clinical Cardiology Basic Science and Circulation, so  
9       why don't you -- you just mentioned that you just left  
10      the 1998 convention of the American Heart Association.

11                  Tell us in a general way what your  
12      relationship over the years has been with the American  
13      Heart Association.

14           A. I've been very active in the American Heart  
15      Association throughout really all my career in  
16      cardiology. I've mentioned the established  
17      investigator support. When I was in Boston, I served  
18      on the board of directors of the Massachusetts  
19      affiliate. I was vice-president and then  
20      president-elect of the Massachusetts affiliate.

21                  Now, in San Francisco I'm on the board of  
22      directors there of the Heart Association, and I've been  
23      very active on the National Heart Association in  
24      Dallas. I was on the research committee there for  
25      eight years, and I'm on currently the public affairs

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1       committee and on the education committee.

2           Q.    Now, you're also a fellow of the American  
3   College of Cardiology, and how does the American  
4   College of Cardiology differ from the American Heart  
5   Association?

6           A.    The American College of Cardiology is our  
7   professional organization insofar as we are practicing  
8   physicians.  So this addresses issues of clinical  
9   practice, and is a professional organization, whereas  
10   the American Heart Association is focused more on  
11   research and on public education.

12          Q.    Then there's a section where you talk about  
13   your editorial responsibilities with respect to various  
14   medical journals, such as the Journal of Clinical  
15   Investigation, the New England Journal of Medicine, the  
16   Annals of Internal Medicine.

17                Tell us in a general way what your editorial  
18   responsibilities have been over the years with respect  
19   to some of these publications.

20          A.    Generally, the medical journals need to have  
21   individuals who will be reviewing articles submitted  
22   for publication, particularly journals such as the New  
23   England Journal of Medicine that get thousands of  
24   articles submitted, so these journals generally pick  
25   individuals who have done research and have a lot of

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1     experience in the various specific subjects, and ask  
2     them to review the articles and make a recommendation  
3     as to whether the articles should be published, should  
4     not be published, should be published with revision,  
5     and that's -- so I've served as an editorial board  
6     member for quite a few journals over the years in that  
7     capacity.

8           Q.     In that capacity, do you make decisions as to  
9     the acceptability of articles that are submitted as to  
10    whether they are actually going to be published in a  
11    given journal?

12          A.     No. I make recommendations as a reviewer.  
13    The decisions are only made by the editor of the  
14    journal, the final decision.

15          Q.     You are a diplomate of the American Board of  
16    Internal Medicine and you are a diplomate of the  
17    subspecialty of cardiovascular disease.

18                 Tell us how one becomes a diplomate of both  
19    boards.

20          A.     To become board-certified in internal  
21    medicine and cardiovascular diseases, it's necessary to  
22    finish an approved training program, and to have  
23    letters written to -- in support of your having the  
24    appropriate expertise, and finally to pass a written  
25    and in my case at that time there was also an oral

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1 examination, to be certified.

2 Q. Now, one of the various honors you've  
3 received, Phi Beta Kappa, and that refers to what  
4 degree?

5 A. That was for my undergraduate work.

6 Q. Now, then, there is a section where you are  
7 listed as a principal investigator for a variety of  
8 subjects relating to the heart. Does that involve your  
9 own personal research or research that you direct?

10 A. Yes. The majority of those were related to  
11 my own personal research. I believe one that's listed  
12 on my curriculum vitae is related to my directing a  
13 training grant which basically meant that I was  
14 training young cardiologists to develop into  
15 researchers.

16 Q. Explain, if you would, you know, this general  
17 concept. We hear on the one hand of heart disease, and  
18 then we hear about heart attacks.

19 Now, I assume it's possible to have very  
20 serious heart disease without actually having a heart  
21 attack.

22 A. That's correct.

23 Q. Okay.

24 A. There are many forms of heart disease.

25 Coronary heart disease is the commonest in certainly

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1     the United States, and becoming rapidly the commonest  
2     form of heart disease throughout the world. Coronary  
3     heart disease is heart disease in which blockages in  
4     the coronary arteries, as I mentioned earlier, lead to  
5     a low oxygen state, lack of proper oxygenation of the  
6     heart muscle, and the most severe form of that is a  
7     heart attack, when the oxygen is critically reduced.

8             There are other forms of heart disease,  
9     however, that have nothing to do with the coronary  
10    heart disease, such as valvular heart disease, rhythm  
11    disturbances of the heart, infections of the heart.

12            Q.    When we hear about -- when I say hear about,  
13    you read in the paper or hear anecdotal evidence about  
14    people who never knew they had a heart problem, thought  
15    they were in perfectly good health and then have a  
16    sudden heart attack which seemingly arises out of the  
17    blue.

18            What generally accounts for that, where a  
19    person has been going to doctors on a regular basis,  
20    has not been diagnosed with heart disease and yet has a  
21    sudden heart attack?

22            A.    Unfortunately, that's a very common scenario,  
23    because the plaques that build up inside the coronary  
24    arteries usually build up slowly and gradually with  
25    time. And compensatory mechanisms develop to allow the

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1 heart to function with its reduced flow and oxygen.

2 But commonly, at some point, for reasons that  
3 are now being unraveled, the plaque actually ruptures.  
4 It breaks open, exposing the underlying cholesterol and  
5 other contents of the plaque, and on this surface a  
6 blood clot forms, and if the blood clot occludes or  
7 blocks the artery completely, a heart attack will  
8 ensue.

9 Q. What are the basic structures of the heart?

10 A. The basic structures are the coronary  
11 arteries, which feed the heart muscle, the four  
12 chambers of the heart, which are the pumping chambers,  
13 and the four cardiac valves.

14 Q. The pumping chambers are called what? I  
15 mean, I've heard of ventricles.

16 A. There are two atria and two ventricles.  
17 Blood comes back into the heart from the body, from  
18 your legs, liver, brain, and enters the right atrium.  
19 All blood returning to the heart enters the right  
20 atrium.

21 It is then pumped into the right ventricle,  
22 which pumps the blood through the pulmonary valve into  
23 the lungs. In the lungs, the blood gives up carbon  
24 dioxide and takes on oxygen and then passes over to the  
25 left side of the heart, where it enters the left

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1     atrium, booster pump action of the left atrium pushes  
2     the blood into the left ventricle, and from the left  
3     ventricle the blood is ejected to the brain and the  
4     entire body.

5           Q.   Obviously a certain number of people die from  
6     heart attacks, and then there is another group of  
7     people, they have a serious heart attack and they make  
8     a very good recovery, and they go back to leading a  
9     relatively normal life.

10           What usually -- what generally accounts for  
11     the difference in outcome?

12           A.   There are a number of things --

13           Q.   I know I'm asking you a lot of really, very  
14     basic questions.

15           A.   Right. Well, people will have a heart  
16     attack. Some will die before they ever get to a  
17     hospital; others will get to a hospital but will die in  
18     the hospital.

19           But fortunately, today the majority of people  
20     who actually do make it to a hospital will live and be  
21     able to get a second chance.

22           The things that determine -- the factors that  
23     determine whether you will die with that first heart  
24     attack, I would say the most important factor is the  
25     location of the blockage that causes the heart attack.

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1           We know that if the blockage happens to be in  
2   the left main coronary artery or in the very early part  
3   of the left anterior descending coronary artery, the  
4   blockage will usually be fatal. In fact, when I was in  
5   medical school, the left anterior descending artery, we  
6   were told the other name for that was the widow maker.

7           Q.   Because the outcome was usually so --

8           A.   Because the outcome was usually fatal.

9           Q.   Doctor, one of the longest sections of your  
10   curriculum vitae is your bibliography which includes  
11   original articles by you, and I've counted them up and  
12   they're a total of 187 articles by you which have  
13   appeared in a variety of medical journals. And  
14   naturally I'm not going to cover anything approaching  
15   all of them. But tell us generally on what subjects  
16   you have written on most frequently.

17          A.   I've written on a variety of subjects.

18   Written on cardiac catheterization, coronary  
19   angiography. Early in my career I studied valvular  
20   heart disease quite a bit. More recently, I have  
21   studied heart failure and something called diastolic  
22   dysfunction which is the -- refers to the heart's  
23   ability to relax normally.

24               And most recently in the last few years, I've  
25   studied the effects of anti-platelet drugs in the

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1 patient with unstable angina and myocardial infarction.

2 Q. And name some of the representative  
3 publications where perhaps a majority of your articles  
4 have appeared.

5 A. Circulation is one. That journal is  
6 published -- you're asking for the names of the  
7 journals?

8 Q. Correct.

9 A. Circulation is published by the American  
10 Heart Association. It's the official journal of the  
11 American Heart Association.

12 The New England Journal of Medicine is  
13 another. Although it has a regional title, it's  
14 probably the most widely-read journal in the world in  
15 terms of major breakthroughs and new treatments.

16 The Journal of the American College of  
17 Cardiology is another. I would say that those are  
18 probably the three commonest journals that I submit my  
19 articles to.

20 Q. And just to pick a few articles and ask you  
21 essentially what the thrust of them was, an article,  
22 the title of which is: Blood Oxygen Measurements and  
23 the Assessment of Intracardiac Left to Right Shunts, is  
24 a critical appraisal of methodology, and I'm certainly  
25 not asking for a technical explanation, but, in

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1       general, what were you conveying in that article?

2           A.     That was an article trying to -- we did a  
3       study trying to improve the ability of cardiac  
4       catheterization to detect and to accurately assess  
5       congenital heart disease.  People who have -- were born  
6       with holes in their heart, you really need to do a test  
7       to tell is the hole there and then does it need to be  
8       fixed, and that was what the purpose of that study was.

9           Q.     You did an article which appeared in the  
10      Journal of the American College of Cardiology in 1986:  
11      Survival of Patients With Refractory Congestive Heart  
12      Failure Treated With Oral Milrinone.  I'm sure I'm not  
13      pronouncing that.

14                  First of all, what is congestive heart  
15      failure and what was the thrust of this article?

16           A.     Congestive heart failure is a condition in  
17      which the heart is not able to pump blood adequately to  
18      the body.  The blood backs up into the lungs causing  
19      shortness of breath, may back up into the legs calling  
20      swelling and edema of the legs, and Milrinone -- you  
21      did pronounce it correctly -- is a drug that was  
22      developed at that time and is currently on the market  
23      as an available drug for the treatment of heart  
24      failure.

25           Q.     You've written several books?

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1           A.    Yes.

2           Q.    You've been the editor of several books; is  
3   that correct?

4           A.    Yes.

5           Q.    Okay.  Now, I think one of the books you  
6   edited, the title of which is:  Profiles in Valvular  
7   Heart Disease, what was the focus of that book?

8           A.    Well, that was actually a chapter in my  
9   textbook, Cardiac Catheterization, Angiography and  
10   Intervention, and the thrust of that was a description  
11   of what one would expect to find in a patient with  
12   various types of valvular disease, if there was  
13   something wrong with the mitral valve, how would the  
14   patient present?  What would be the findings?

15                If the patient had disease of the aortic  
16   valve, what would be the patient expect?  What would be  
17   the condition that would cause the physician to  
18   recommend the patient for heart surgery or other  
19   treatment?

20           Q.    You've written on the subject of the current  
21   management of angina pectoris.

22                To me that means chest pain; is that correct?

23           A.    Yes.

24           Q.    And what is the best treatment of that today?

25           A.    Well, today the best treatment is to stop

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1     smoking, if you're smoking; to be on appropriate  
2     medicines, which today would include an aspirin or  
3     other anti-platelet drug taken daily; perhaps nitrates,  
4     such as nitroglycerin tablets, correction of abnormal  
5     cholesterol, if that's a problem, and certainly control  
6     of blood pressure, if that's a problem.

7           Q.    What is the relationship of high blood  
8     pressure to heart disease, cardiac problems, in  
9     general?

10          A.    We know from epidemiologic studies, such as  
11     the Framingham study and other studies, that patients  
12     who have high blood pressure have a greater likelihood  
13     of developing a heart attack and/or stroke, and  
14     developing these conditions earlier than people without  
15     high blood pressure.

16          Q.    There is a section of your curriculum vitae,  
17     Review Articles and Chapters. Tell us in a general way  
18     about some of the subjects you covered there.

19          A.    Well, of course, I have written textbooks  
20     myself as you've mentioned, but colleagues of mine  
21     across the country also have written textbooks, and  
22     they have often asked me to contribute to their  
23     textbooks by writing chapters. So I have written  
24     chapters for them on heart failure, diastolic  
25     dysfunction, and a number of subjects.

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1           Q.    Dr. Grossman, does cigarette smoking cause  
2   heart disease?

3           A.    There's no question in my mind that cigarette  
4   smoking causes heart disease.

5           Q.    And is that answer based upon reasonable  
6   medical certainty?

7           A.    Yes.

8           Q.    And what specific types of heart disease does  
9   cigarette smoking cause?

10          A.    Cigarette smoking causes coronary thrombosis  
11   and myocardial infarction, or heart attack.  It can  
12   cause angina pectoris if the blockage is less severe.  
13   And when the blockage is more severe, it leads to a  
14   full heart attack.

15          Q.    Now, for example, when you attend a  
16   convention as you just have of the American Heart  
17   Association, and when you talk about some 45,000  
18   doctors worldwide belonging to this organization, are  
19   there a variety of committees studying and talking  
20   about various aspects of heart disease?

21          A.    Yes.  There are at least 20 committees on the  
22   National American Heart Association.

23          Q.    And in terms of these committees, the way  
24   they're set up, are a variety of subjects not only  
25   discussed but actually debated --

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1           A.    Yes.

2           Q.    -- where some doctors believe one thing and  
3   other doctors believe another thing?

4           A.    Yes, there are debates annually as part of  
5   the meeting.  In fact, the debates are one of the  
6   livelier parts of the meeting and very well attended.  
7   There are debates not only for the American Heart  
8   Association's annual meeting, but for the American  
9   College of Cardiology annual meeting, and I always try  
10   to go to their sessions because they're stimulating and  
11   they're very informative.

12          Q.    Dr. Grossman, in terms of these debates which  
13   take place at meetings of the American Heart  
14   Association or the American College of Cardiology  
15   meetings, are there any debates going on on the subject  
16   of whether or not cigarette smoking causes heart  
17   disease?

18          A.    In my medical career, I have never seen  
19   debate on that subject at the American Heart  
20   Association's meeting or the American College of  
21   Cardiology meeting.  I never heard of that debate  
22   taking place at any major scientific meeting.

23          Q.    Where is that?

24          A.    The question is settled.  It's not a question  
25   that anyone that I know in the cardiology community

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1 debates.

2           Everyone has pretty much come to accept that  
3 smoking causes heart disease, particularly causes  
4 myocardial infarction.

5           Q.   If someone -- myocardial infarction being the  
6 medical term for heart attack?

7           A.   Yes.

8           Q.   If someone comes to you as a patient and they  
9 tell you that they're a smoker, and you examine them,  
10 and on examination they're fine, they don't have heart  
11 disease, you have no reason to believe that they're  
12 going to have a heart attack any time soon; their  
13 cholesterol is okay; they don't have high blood  
14 pressure.

15                  What recommendation, if any, will you make  
16 with respect to their smoking?

17           A.   I make a very strong recommendation to every  
18 smoker that I see medically to stop smoking. Whether  
19 they have heart disease or not is irrelevant, and I  
20 don't wait for patients to develop a heart attack  
21 before I tell them to stop smoking.

22                  In the earlier part of my career, most of the  
23 patients that I saw who were smokers and who came to my  
24 attention, came to my attention because they already  
25 had coronary heart disease. I saw them in the cardiac

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1 catheterization laboratory where they were sent because  
2 they had angina or had had a heart attack.

3 In my current activities, many people seek me  
4 out for my cardiology consultation, my advice. So I do  
5 see patients now who don't have any heart disease, but  
6 who don't want to get heart disease. And that is the  
7 most important thing that I do, is try to get them to  
8 stop smoking, if they are smoking.

9 Q. Why is that so significant? Why do you make  
10 that recommendation universally?

11 A. I've seen a number of patients over the  
12 years, where they presented with a heart attack,  
13 sometimes fatal heart attack, and there was no other  
14 obvious cause of heart disease, no other discernible  
15 cause of heart disease; and I just think it's critical  
16 for us not to play Russian roulette and take a chance.

17 If a patient has high blood pressure, you  
18 usually have a fair amount of time in which the  
19 condition becomes manifest, and you can institute  
20 treatment. Similarly with high cholesterol.

21 But with cigarette smoking it's very common,  
22 in my experience, that -- particularly in the younger  
23 patient, that they have some catastrophic event.

24 Q. Have you had occasion to follow patients who  
25 had a certain amount of heart disease where you

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1 recommended that they stop smoking, and they followed  
2 your recommendation and in fact did stop smoking, and  
3 you continued to follow them with respect to that group  
4 or that category of people. How did they generally do  
5 medically?

6 A. Generally, patients who stop smoking do well,  
7 assuming that other factors are also treated  
8 appropriately.

9 Obviously, you don't let them have high blood  
10 pressure just because they are no longer smoking. But  
11 I've seen a number of patients who presented early. I  
12 recall one man who had a heart attack at age 40 stop  
13 smoking and then did well for 20 plus years, still  
14 doing well last I saw him a few months ago.

15 The problem occurs in the patients who don't  
16 stop smoking. Unfortunately, there are a fair number  
17 of those. They want to stop, they try to stop, but  
18 it's not that they debate me and say: Oh,  
19 Dr. Grossman. I think you're wrong. I think I should  
20 be allowed to continue to smoke.

21 They try to stop, but they can't stop. And  
22 that's a real tough problem. When I have patients like  
23 that, I tell the family that I'll do what I can, but  
24 the prognosis is guarded.

25 Q. Are you still a hands-on practitioner?

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1           A.    Yes.

2           Q.    You see patients?

3           A.    Yes.

4           Q.    With respect to patients who have heart  
5    disease and where you have made a strong and consistent  
6    recommendation that they stop smoking, and they  
7    continue to see you and you continue to make that  
8    recommendation, and they continue to smoke, do you  
9    think that this subset of people simply lacked the  
10   necessary motivation or willpower; that they're not  
11   sincere about trying to quit?

12          A.    Not at all.  And --

13          Q.    Why do you say that, that it's not at all --  
14   that it's not only a matter of motivation and  
15   willpower?

16          A.    Well, of course, it's hard to know what's  
17   actually going on inside anyone's head.  I can't tell  
18   exactly what someone is thinking.  They could be lying  
19   to me.  But I have a number of patients who do a pretty  
20   good job of convincing me that they really want to stop  
21   smoking.  And I think they try.  I prescribe Nicotrol.  
22   We go through all these things.  We prescribe the  
23   various drugs, make an attempt.

24                Now, some people definitely do stop, so I'm  
25   not suggesting that no one stops.  Clearly, there are a

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1       number of patients who do stop. But some can't, and I  
2       think they really are trying.

3           Q.    You think those people who convince you that  
4       they sincerely want to quit smoking and can't, do you  
5       think they're addicted?

6           A.    I think so.

7           Q.    Does this statement make any medical sense to  
8       you? Is this a valid statement, or an invalid  
9       statement, from a scientific and medical standpoint?

10           Cigarette smoking may be a risk factor for  
11       heart disease, but it certainly hasn't been  
12       scientifically proven that cigarette smoking causes  
13       heart disease?

14           A.    I don't regard that as a valid statement.

15           Q.    Why not?

16           A.    Cigarette smoking, from the point of view of  
17       epidemiologic studies, is a risk factor. When you are  
18       an epidemiologist, you don't see individual patients.  
19       You study thousands of patients who have filled out  
20       questionnaires, and you look at the questionnaires and  
21       you say: Let's run this statistically and see if  
22       there's any correlation.

23           If there is a correlation, you say: Well,  
24       that's a risk factors, because it correlates with the  
25       outcome.

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1                   However, when you take care of individual  
2     patients, you have a different way of evaluating what  
3     is causal and what isn't causal. And when you see  
4     patients who, particularly -- again, I'm talking about  
5     younger patients where there is no other identifiable  
6     cause, who smoke, they have a heart attack, they stop  
7     smoking, they don't have another heart attack, they do  
8     very well for long periods of time, that's as much  
9     scientific proof as we get in clinical medicine.

10           Q.    You know, Dr. Grossman, I've got some notes  
11    here, and I think we've covered the concept of coronary  
12    atherosclerosis already in your earlier testimony,  
13    although we may not have called it specifically that,  
14    but that's where the arteries get blockages. Is that  
15    the same concept?

16           A.    Yes. The term "atherosclerosis" is the  
17    scientific term applied to the process whereby plaques  
18    develop in the arteries. It can be in the coronary  
19    arteries. Then it's called coronary atherosclerosis.  
20    But the same process affects the coronary arteries,  
21    causes the stroke, affects the peripheral arteries, and  
22    causes potentially gangrene of the feet. So it's a  
23    process that can affect arteries anywhere in the body.

24           Q.    Why is it, does medical science know, that  
25    some people or you take people that have similar diets,

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1 the wrong kind of diet, they smoke, they might have  
2 hypertension, and one of them gets very significant  
3 heart disease, and the other doesn't. When does that  
4 have to do with defense mechanisms of some kind? Would  
5 you explain that? What is protecting the person who  
6 does all the wrong things but doesn't get serious heart  
7 disease?

8 A. It's an excellent question. I wish I knew  
9 the answer.

10 There are clearly genetic variability, so  
11 that some people seem to have protection. Some people  
12 don't get addicted. Some people can eat steak and eggs  
13 and bacon, and their cholesterol stays extremely low.

14 So there are mechanisms. That's an important  
15 subject to research. There is a lot of research going  
16 on, and hopefully we will find the answers with time.

17 Q. Dr. Grossman, on the subject of tobacco  
18 addiction, nicotine addiction, any opinion that you've  
19 expressed here today on that subject has been related  
20 to your own practice and your own hands-on patient  
21 care; is that correct?

22 A. It's certainly correct. I'm not an expert on  
23 addiction from a point of view of my prior research or  
24 from the point of view of having special addiction  
25 practices. But I'm a physician. I see patients who

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1 are taking medicines, who have certain habits. Some  
2 are addicted to excess alcohol. I certainly have had a  
3 number of alcoholics in my practice over the years.

4 Some are addicted to overeating, and some are  
5 addicted to cigarette smoking.

6 Q. And with respect to some of your patients,  
7 you have concluded that by not following your  
8 recommendations and by concluding that they've  
9 sincerely tried, you've concluded the person was  
10 addicted to nicotine; is that correct?

11 A. That is correct.

12 MR. REID: I'm Ben Reid.

13 THE VIDEOGRAPHER: Going off the video  
14 record. We're back on the video record.

15 CROSS-EXAMINATION

16 BY MR. REID:

17 Q. Dr. Grossman, my name is Ben Reid and I  
18 represent Reynolds Tobacco Company. We've not met  
19 before this morning, I suppose.

20 I have a few questions that I'll ask, and  
21 hopefully ask for all the other folks, and we won't  
22 have to spend too much more time here today.

23 I wanted to go back to the area of your  
24 expertise and ask you a few questions about that.

25 I take it there are a number of specialties

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1 or subspecialties or areas of practice within the  
2 overall area of the heart; is that fair to say?

3 A. Yes.

4 Q. And you've specialized or focused your  
5 research and your practice in particular areas; is that  
6 fair to say?

7 A. I think I should clarify my answer there.

8 You said I've concentrated my research and my  
9 practice in certain areas. I have concentrated my  
10 research in certain areas. But my practice has been a  
11 general cardiology practice.

12 Q. Okay. And I think you told us in your  
13 deposition that your research is focused on the  
14 function of the heart muscle, the pumping action of the  
15 heart, and how that might relate to heart failure or  
16 coronary heart disease?

17 A. That's been a major focus of my research,  
18 yes.

19 Q. And you have not focused on the etiology or  
20 the cause of coronary heart disease or any other  
21 specific form of heart disease, have you?

22 A. Certainly not on the etiology of coronary  
23 heart disease. I have done research on the etiology of  
24 heart failure and cardiomyopathy.

25 Q. And in looking at your CV, the writings that

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1       you've done generally don't deal with particular types  
2       of heart disease, do they?

3           A.    I wouldn't say that.

4           Q.    Well, have you written anything, for  
5       instance, dealing with various risk factors associated  
6       with heart disease?

7           A.    Not as such, not in that particular topic.

8           Q.    And I didn't notice in your CV, I think  
9       Mr. Rosenblatt said you'd written, what was it,  
10      180-some articles.

11                  I didn't see anything that seemed to relate  
12      to the effects of smoking on the health of the heart or  
13      heart disease.

14          A.    That's correct.

15          Q.    And in going over your background a minute  
16      ago, I don't -- this may have been mentioned, but I'm  
17      not sure that it was; you spent a period of time  
18      working for a drug company, didn't you?

19          A.    That's correct. I worked for Merck  
20      Pharmaceuticals.

21          Q.    And you were studying the effects of that  
22      company's drugs on the hearts of its customers?

23          A.    That's not quite accurate. I was hired in  
24      1994 to be head of cardiovascular clinical research for  
25      Merck, and the nature of my job there was development

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1 of new treatments for patients with coronary heart  
2 disease and hypertension and heart failure.

3 So the treatments were not for Merck's  
4 customers. There were no customers involved. It was  
5 really research.

6 Q. Well, ultimately leading to the users of its  
7 products. That's what I meant by customers.

8 A. That was their goal, yes.

9 Q. Okay. I think you mentioned that one of the  
10 attractions of that job was never having to write a  
11 grant request again to the National Institutes of  
12 Health for the rest of your life?

13 A. That was definitely one of the selling points  
14 that they made in trying to recruit me, yes.

15 Q. Now, you've used the word "cause" today in  
16 your testimony several times, and I want to talk with  
17 you a little bit about how scientists go about arriving  
18 at decisions and conclusions.

19 Would you agree with me -- and you've already  
20 mentioned this -- that one way that scientists study  
21 issues relates to the study of epidemiology?

22 A. Yes.

23 Q. And tell us -- the jury has heard from people  
24 about this, but what do you consider epidemiology to  
25 be?

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1           A.    Well, I'm not an epidemiologist, but  
2    epidemiology, as I understand it, is the study of  
3    disease in populations, in large groups of people.

4           Q.    And part of the scientific method would  
5    include the study of epidemiological evidence, if  
6    you're trying to find out whether an agent causes a  
7    particular disease?

8           A.    Epidemiology usually points one in a  
9    direction that then has to be followed up in laboratory  
10   experiments.

11          Q.    Now, moving to the second thing that you've  
12   sort of mentioned, another area of research would be  
13   animal studies, animal research; is that fair to say?

14          A.    Yes.

15          Q.    And that would be part of the scientific  
16   method if you were trying to determine cause of an  
17   agent, whether a particular agent causes a particular  
18   disease; is that fair to say?

19          A.    It would be part of the scientific method to  
20   determine whether that agent causes the disease in  
21   animals.

22          Q.    Sure, sure.

23                And then a third area, perhaps, that we might  
24   consider as part of the scientific method would be the  
25   study of the actual mechanism, the biological mechanism

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1 of the disease that you're interested in; is that fair  
2 to say?

3 A. Yes.

4 Q. I'm just writing these things down so I'll  
5 remember what we talked about.

6 In your experience, you've dealt with  
7 research where there's been evidence in some of these  
8 areas and perhaps not in others?

9 A. Yes.

10 Q. And you might have epidemiology evidence but  
11 maybe no animal evidence yet, no animal study evidence?

12 A. Yes.

13 Q. Or you might have the first two and maybe no  
14 mechanism evidence hasn't developed yet?

15 A. Correct.

16 Q. And that's why you do research and you do  
17 scientific study, is that right, to try to get evidence  
18 in all three areas, if you can?

19 A. Correct.

20 Q. And that's something that you've done on a  
21 regular basis throughout your career as a physician and  
22 a scientist?

23 A. Well, I've done parts of that. I certainly  
24 haven't done epidemiologic research.

25 Q. Okay. I would like, if we could, to talk

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1       about each of those in turn a little bit today, and  
2       start with epidemiology.

3               Now, I understand you don't hold yourself out  
4       as an expert and you've not been involved, but you have  
5       I suppose looked at epidemiology from time to time in  
6       your career?

7               A.    Yes.  I certainly read the articles in the  
8       journals and listen to the presentations at the  
9       scientific meetings.

10              Q.    And I think you told me or you mentioned  
11       before that rather than being experimental, that  
12       epidemiology is descriptive?

13              A.    That's correct.

14              Q.    Is that a good way to say it?

15                 Now, the 1983 Surgeon General's Report refers  
16       to smoking as a risk factor for heart disease, is that  
17       correct, uses that term?

18              A.    I believe it uses that term, yeah.

19              Q.    And it's fair to say that the principal  
20       association of cigarette smoking to coronary artery  
21       disease is in the epidemiology field?

22              A.    Would you repeat that?

23              Q.    Yes.  My question is this:  The association  
24       between cigarette smoking on the one hand and coronary  
25       artery disease on the other has been found in

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1 epidemiologic studies?

2 A. That's where it was first established as a  
3 pattern.

4 Q. Now, would you agree --

5 A. But I wouldn't say that's the only area it's  
6 been identified.

7 Q. I plan to talk -- we're going to talk about  
8 all the areas before we finish. Right now I just want  
9 to talk about epidemiology.

10 You would agree that you can't prove cause by  
11 epidemiology alone, can you?

12 A. I think that's probably correct. I would  
13 have to think about that, but I guess that's probably  
14 correct.

15 Q. And I think you told us earlier today that  
16 the epidemiologic studies would suggest theories of  
17 causation that you'd either have to prove or disprove  
18 using the other methods of research: animal studies,  
19 mechanism studies; is that fair to say?

20 A. Generally, that's correct.

21 Q. And I think you said if you made judgments  
22 solely based on epidemiology, you could just have  
23 computers diagnosing and treating patients, then,  
24 couldn't you?

25 A. That's an interesting way to put it.

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1           Q.    Well, that's how you put it, isn't it, in  
2    your deposition, I think?

3           A.    I may have said that.

4           Q.    Okay.

5           A.    But -- I'll take your word for it.  If I said  
6    that --

7           Q.    Sure.  I mean, it's a fairly accurate  
8    statement, isn't it?  If you could do it on  
9    epidemiology, you wouldn't need physicians to do other  
10   things, would you?

11          A.    I guess that's correct.

12          Q.    And sometimes -- are you aware of situations  
13   where epidemiology has suggested a relationship that  
14   when you got to the later types of proofs, the  
15   relationship was not borne out in fact?

16          A.    Give me an example.

17          Q.    Well, I will, but can you, as you sit here  
18   today, you can't recall any that you've personally or  
19   had first-hand experience with or read about?

20          A.    I can't right now, but I'm sure I could if I  
21   gave it a little bit more thought.

22          Q.    Okay.  Let's talk about estrogen for  
23   instance.  There is an epidemiologic basis for  
24   suggesting that premenopausal women are less likely to  
25   have heart disease than post-menopausal women; is that

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1 fair to say?

2 A. Yes.

3 Q. And that was based on epidemiology initially?

4 A. Yes.

5 Q. And many doctors, based on epidemiology, feel

6 that a treatment is warranted; that is, estrogen

7 supplements to people who have passed menopause?

8 A. Yes.

9 Q. And that's a decision made based on

10 epidemiology, isn't it?

11 A. It's a decision that doctors have based

12 partly on epidemiology, but partly on some studies that

13 have been done where women have been treated with

14 estrogen and have had positive results.

15 Q. I think --

16 A. Not all the studies have shown positive

17 results. I guess that's what you're leading to.

18 Q. And I guess you told us that you in fact

19 diagnosed or prescribed, I should say, estrogen to

20 people, to women who were post-menopausal for this

21 reason?

22 A. Yes.

23 Q. Now, you're familiar with the Journal of the

24 American Medical Association, aren't you?

25 A. Yes.

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1           Q.    And you'd consider that to be an  
2   authoritative treatise?

3           A.    Yes.

4           Q.    Are you familiar with a study that is a  
5   randomized trial clinical study, double blind and so  
6   forth, that's been done on the subject of estrogen  
7   supplements?

8           A.    Yes.

9           Q.    And in fact, what study are you familiar  
10   with?

11          A.    I think you're probably referring to the HERS  
12   trial, which was recently published.

13          Q.    Right.  Came out in August?

14          A.    Yes.

15          Q.    And the conclusion there was, in that  
16   particular study, that estrogen had some negative  
17   impacts on the patients; is that correct?

18          A.    No.  That's not correct.

19                I believe the lead author on that was  
20   Dr. Hulley.

21          Q.    Dr. Hulley?

22          A.    At the University of California, San  
23   Francisco.  He is a colleague of mine, and I discussed  
24   this with him at length.

25                The conclusion in the article and of that

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1 study is that estrogens administered in that particular  
2 formulation, which is an usual formula -- it was  
3 estrogen combined with progestin continually without  
4 the cycling that I prescribe in my practice of 25 days  
5 of Premarin and five days of progestin, but given in  
6 the way that it was given there, and instituted only  
7 after the development of coronary disease had come  
8 about, that it had no benefit.

9 In fact, the average age of patient entered  
10 in that study I believe was 65, whereas in my practice  
11 I try to enter women on estrogen hormone replacement  
12 therapy at the time of menopause, before they've had a  
13 heart attack.

14 Q. And I understand what you're saying about  
15 whether you agree with the results or whether you can  
16 explain the results compared to other results.

17 But this particular study with the use of  
18 estrogen did demonstrate an increased rate of  
19 gallbladder disease, as well as some other  
20 heart-related problems?

21 MR. ROSENBLATT: Why don't you show the  
22 doctor the article.

23 MR. REID: Sure.

24 BY MR. REID:

25 Q. Is that a fact, that these particular people

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1 found an increase in gallbladder disease?

2 A. I don't really remember that, but I'm sure --

3 Q. Okay. Look at the conclusion section, then?

4 A. Conclusions, okay.

5 Treatment did increase the rate of

6 thromboembolic events and gallbladder disease, yes, I

7 see that.

8 Q. Also this particular study found no

9 cardiovascular benefit?

10 A. Yes.

11 Q. And in fact, pattern of early increase in

12 risk of CHD -- which stands for what?

13 A. Coronary heart disease.

14 Q. -- events; is that correct?

15 A. Yes.

16 Q. And Dr. Hulley, in his group, recommended not

17 starting the treatment for secondary prevention of

18 coronary heart disease; is that correct?

19 A. He recommended not starting this particular

20 treatment --

21 Q. Sure.

22 A. -- in patients who had already had a heart

23 attack.

24 Q. Sure. But part of this study, the

25 epidemiology would have suggested something to the

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1       contrary; is it fair to say?

2           A.    No, I disagree. I think you're raising the  
3       study -- it's a very good example of where scientific  
4       research helps us clarify something that epidemiology  
5       hints at.

6           As you said, we learn from epidemiology that  
7       women who are premenopausal have a very low incidence  
8       of heart attack, but post-menopausal they have an  
9       incidence of heart attack equaling that and eventually  
10      exceeding that of men.

11          So the question is, what is the difference?  
12      Well, one group is younger, one is older, but also  
13      there's something having to do with estrogen.

14          Now, this study used estrogen, but it didn't  
15      use it in that natural way. These women didn't have  
16      periods. These women were not being given cycling  
17      estrogen.

18          So now we're learning that maybe it isn't  
19      just having estrogen, but it's having estrogen in a  
20      certain way, the natural way of cycling it, but it  
21      might be that we'll find out that even that doesn't  
22      help and it has nothing to do with estrogen.

23          So you are right in that sense. We do need  
24      to do scientific studies. The epidemiologic studies  
25      are really only giving you a starting point.

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1           Q.    And I suppose that would be, as you said,  
2       this would be a good example of why you need to go  
3       through all the areas of scientific method that we  
4       talked about, if you can.

5           A.    Exactly. I didn't mean to, you know, go into  
6       detail on the estrogen thing, but I think it's an  
7       important example. And I think it's also important  
8       that anyone hearing this testimony, members of the  
9       jury, not stop taking their estrogen, because I  
10      continue my patients on their estrogen, and I don't  
11      think this study means that women should stop taking  
12      their estrogen.

13          Q.    Of course my question isn't -- has nothing to  
14      do with whether someone should do it or not, and I  
15      think you understand the point of the discussion, and  
16      that is, that it takes sometimes more than epidemiology  
17      to carry out the scientific method?

18          A.    Yes.

19          Q.    Okay. Now, wouldn't ulcers, stomach ulcers,  
20      be another example where the epidemiology suggested  
21      stress, diet, things such as that, and when it turned  
22      out when the rest of the scientific method was carried  
23      out, it was found to be caused by bacteria?

24          A.    Yes, that's correct.

25          Q.    Okay. Let's change and talk about animals

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1 for a minute, animal studies.

2 It's a fact, isn't it, Doctor, that there's  
3 been no animal model which has developed coronary  
4 artery disease in animals using whole smoke?

5 A. I'm not really --

6 Q. Whole smoke.

7 A. I'm not really expert enough on the  
8 literature to answer that question.

9 Q. Well, if there was testimony that the jury  
10 heard previously from another expert, a plaintiff, that  
11 there are no such studies, would you agree with that  
12 testimony?

13 A. I probably would, but -- you know, I really  
14 haven't made a study of that literature myself.

15 Q. And with regard to your opinion that you gave  
16 about cause a minute ago to Mr. Rosenblatt, if there  
17 were in fact no animal models, which have reproduced  
18 coronary artery disease in animals exposed to whole  
19 smoke, that would affect your opinion as to causation,  
20 wouldn't it?

21 A. Absolutely not.

22 Q. Okay.

23 A. No. I think there's a very --

24 Q. Let me --

25 MR. ROSENBLATT: Let him finish his answer.

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1           A.    I think there is a very important distinction  
2   here between scientific evidence resulting from  
3   research studies and a conclusion that a physician  
4   makes based on his knowledge of individual patients.  
5   I'll give you an example.

6                   I had a patient -- this was several years  
7   ago. It made a very big impression on me. I had a  
8   patient who had a heart attack. He came in the  
9   emergency ward. He had a heart attack, and he was very  
10  sick. And his wife was sitting out in the emergency  
11  ward waiting area.

12                   His wife suddenly started -- with no history  
13  of ever having had any heart trouble, suddenly started  
14  having chest pain, and she had a cardiac arrest and she  
15  died.

16                   Now, I don't know of any animal experimental  
17  data that would tell me, you know, what was the cause.  
18  But I know what was the cause of that woman's death.  
19  This woman was under incredible emotional stress  
20  because of her husband being right there in the next  
21  room having a heart attack, and this stress caused a  
22  heart attack in this woman.

23                   I wouldn't say the stress was a risk factor.  
24  It might be a risk factor in thousands of people, but  
25  in her, it was the cause of her fatal heart attack.

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1           Q.    My question to you is this:  Now, if you  
2    learned that there were no animal models that have  
3    reproduced coronary artery disease in animals which  
4    were exposed to whole tobacco smoke, would that have  
5    any effect on your opinion regarding causation of heart  
6    disease by tobacco?

7           A.    No.  Because I think basically I would -- I  
8    would doubt the appropriateness of the animal model.

9                   In other things that I have studied in the  
10   heart, heart failure for instance, we've often found it  
11   extremely difficult to come up with an appropriate  
12   animal model that showed the same characteristics of  
13   the human condition we were looking for.  It's very  
14   difficult.

15          Q.    And now, Doctor, I want to ask you if you  
16   remember giving this testimony, Page 79:

17                Question:  Would it make any difference in  
18   your opinion that cigarette smoking had been shown to  
19   cause cardiovascular disease if you were satisfied that  
20   cigarette smoke had never been shown to cause  
21   atherosclerosis in animals?

22                Your answer to that question was:  It  
23   probably would have some influence, but again I would  
24   like to state that this has not been my area of  
25   expertise or research expertise of mine.

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1                   Do you remember giving that testimony?

2           A.    Yes.

3           Q.    And then you -- well, in fairness, you then  
4           described what you did here today, and that is, you are  
5           basing your causation on your personal experience with  
6           patients?

7           A.    That's correct.

8           Q.    Okay. Let's talk about mechanism now, the  
9           third of the three. We've talked about epidemiology  
10          and we've talked about animal studies.

11          And you've given some testimony regarding  
12          this already today, but it's fair to say that at this  
13          point science doesn't really know why the coronary  
14          arteries in one patient remain normal while in another  
15          patient they aren't, assuming they both have the same  
16          exposures?

17          A.    Well, we know a lot.

18          Q.    All right. Is that a fact, we don't know why  
19          one person, assuming two people who are exposed to the  
20          same risk factor, whatever we want to call it, the same  
21          agent, while one has coronary artery disease, and one  
22          doesn't?

23          A.    I would say we need to know a lot more than  
24          we do today. But I wouldn't say that we don't know in  
25          any circumstance.

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1           For instance, patients who have coronary  
2   heart disease with myocardial infarction are often --  
3   they have other things going on that we can determine  
4   by measuring their blood.

5           For instance, they have platelets that are  
6   unusually sticky or they have high fibrinogen levels.  
7   There are things we will find in the individual who has  
8   a heart attack that we don't find in the individual who  
9   smokes who doesn't have a heart attack.

10          I'm not saying those are the exhaustive full  
11   list of difference, but I do think we know some of the  
12   reasons.

13          Q.   Well, for instance, in some populations it's  
14   true, isn't it, that there's no correlation between  
15   cigarette smoking and the development of coronary  
16   artery disease?

17          A.   I don't know the studies you're referring to.  
18   What populations are those?

19          Q.   Well, let me ask you if you recall giving  
20   this testimony. Page 95 -- begins on Page 94,  
21   actually, the question:

22                Let me ask you this question. In light of  
23   the information that's presented in the Surgeon  
24   General's Report and with respect to the autopsy  
25   follow-up of these populations, is it your belief that

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1       for whatever reason, at least in some populations,  
2       there is no correlation between cigarette smoking and  
3       the development of atherosclerosis in the coronary  
4       arteries?

5                Answer: I would agree with that.

6                A. Yes. That question I would agree.

7                Q. And you are familiar with the Puerto Rico  
8       study, aren't you, that you discussed in your  
9       deposition?

10              A. I didn't discuss it, but I think it was shown  
11      to me at the time of my deposition. As I recall, it  
12      was one of the things that was shown to me.

13              Q. And you also were familiar with the Oslo  
14      heart study, were you not, sir?

15              A. I think that was shown to me, too.

16              Q. And you had looked at these before, hadn't  
17      you?

18              A. I had reviewed data that had been sent to me  
19      at my request to get updated in the general area.

20              Q. And in the Puerto Rican heart study, for  
21      instance, there was no statistically significant  
22      relationship between smoking and coronary artery  
23      disease, was there?

24              A. Well, I really don't remember. I would like  
25      to see the study.

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1           Q.    Let me ask you if you recall giving this  
2    testimony.

3           MR. ROSENBLATT:   Page?

4           Q.    Page 90.  It's a long question.

5           But I'm just going to ask you the part about  
6    the quote that was given to you from the study.

7           Quote:  The Honolulu study showed a  
8    significant relationship between smoking habits and  
9    extent of coronary atherosclerosis.  The Oslo study  
10   does not show a significant relationship between  
11   cigarette smoking and coronary atherosclerosis.  The  
12   Puerto Rico study did not show a significant  
13   relationship between smoking and the extent of coronary  
14   atherosclerosis.

15          Have you reviewed the information  
16   sufficiently with respect to those three studies to be  
17   able to agree or disagree with the statements that  
18   those studies showed, that they showed?

19          Answer:  Yes.

20          And do you agree that is in fact what they  
21   showed, what the studied showed?

22          I agree with the statement that the study is  
23   not clear.  There is no clear agreement among those  
24   studies.

25          Do you recall giving that testimony?

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1           A.    I recall it now, yes.

2           Q.    Okay.  And wasn't there also a Japanese heart  
3   study that demonstrated that as the Japanese diet  
4   became more similar to the western diet, then heart  
5   disease rose among smokers?

6           A.    Yes.  That's definitely true.  I remember  
7   that one very clearly.

8           Q.    And in Japan the smoking rates are  
9   substantially higher than they are in the United  
10   States?

11          A.    Yes, but I don't recall any studies showing  
12   that in Japan there was no correlation between  
13   cigarette smoking and atherosclerosis.

14          Q.    You don't recall?

15          A.    No.

16          Q.    Okay.

17          A.    I would be very surprised if there was no  
18   relationship between smoking and atherosclerosis in  
19   Japan.  There is a lot of coronary disease in Japan  
20   now.  There didn't used to be, but there is now.

21          Q.    Now, going back to this question of  
22   mechanism.  What science has attempted to determine  
23   what causes particular heart problems, it's fair to  
24   say, isn't it, that some people just may be immune to  
25   the effect of cigarette smoke?

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1           A.    That's probably true.

2           Q.    And some people would have -- who have heart  
3    attacks who smoke are, in fact, having heart attacks  
4    for other causative factors?

5           A.    I wouldn't say that cigarette smoking is the  
6    only cause of heart attack.

7           Q.    Well, would you agree with me that some  
8    people who have heart attacks have them for other  
9    causative factors?

10          A.    It's hard to know. I mean, if somebody is  
11    smoking and they have a heart attack, how can you say  
12    the smoking was not the cause of the heart attack? All  
13    we know is there are other things that also cause heart  
14    attacks.

15          Q.    And that's something science doesn't know?

16          A.    Science doesn't know it, but if in an  
17    individual patient, if a patient has -- I'll give you  
18    an extreme example. If you come up on a person who is  
19    deceased, dead, and you look at them, and they have a  
20    bullet wound in their temple and they have a knife  
21    sticking out of their heart, and they have obviously  
22    been run over from a truck, I don't think you can  
23    conclude from that that they didn't get killed by the  
24    bullet through the -- you know, I mean, if there are  
25    multiple things that are in the background that could

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1     have killed that person, or in the case of your  
2     question, that lead to a heart attack, I don't see how  
3     you can conclude that the smoking or one of them didn't  
4     cause it.

5           Q.     And I think you've said that for whatever  
6     reason, some people seem to be protected by as yet  
7     unknown features?

8           A.     That's correct.

9           Q.     And the example you gave, some people can  
10    seem to have no negative impact from ultraviolet rays.  
11    They go in the sun a lot and have no problem?

12          A.     I don't remember giving that example. But I  
13    will agree with you that some people seem to be able to  
14    smoke cigarettes through their 90s without obvious  
15    adverse effects. I think that's probably more  
16    important to the point than ultraviolet light.

17          Q.     But you've used ultraviolet light as an  
18    example that science just doesn't understand as to why  
19    people are immune to the ultraviolet light problem that  
20    other people may suffer from; is that fair to say?

21          A.     Well, yes. I have to say I haven't really  
22    had a chance to review all the things that I said in  
23    the hours that I was deposed in May, and so if I don't  
24    remember having said a specific thing, I hope you'll  
25    forgive me. And if it's important, I will be delighted

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1 to look over what I said --

2 Q. Sure.

3 A. -- and see whether I still feel the same.

4 Q. And you're aware of some people that can eat  
5 five eggs every day and yet not have any negative  
6 impact from the cholesterol?

7 A. Yes.

8 Q. So you would agree that there's just some --  
9 perhaps some genetic reason that people respond  
10 differently to various substances?

11 A. Yes.

12 Q. And that's really what science is trying to  
13 discover, as we sit here today?

14 A. That's certainly one thing. It would be very  
15 nice to discover. Then we could all take the  
16 protective factor and eat as many eggs as we want and  
17 do anything else that we want.

18 Q. And you mentioned, the last comment you made,  
19 if you stopped with epidemiology and didn't look at the  
20 other areas, you might never know what protective  
21 factors exist?

22 A. Correct.

23 Q. And that's one of the reasons that the  
24 scientific method includes all three areas?

25 A. Yes.

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1           Q.    Now, I wanted to ask you a question about  
2    angina.  A minute ago you said, when you were asked the  
3    question that it's related to smoking -- do you recall  
4    that testimony today?

5           A.    What I meant to convey was that patients who  
6    have angina can have it on the basis of cigarette  
7    smoking only, without any other causative factor.  I've  
8    seen patients who smoke cigarettes, they get angina,  
9    they stop smoking cigarettes, the angina goes away.

10          Q.    So your testimony about that was based on  
11   some patients that you have seen?

12          A.    Yes.

13          Q.    And you are aware that the Surgeon General  
14   said in the '83 report that the evidence wasn't certain  
15   about whether angina was caused by cigarette smoking?

16          A.    In the Surgeon General's Report, my  
17   understanding is that those conclusions were based on  
18   epidemiologic data, so I don't think that the report  
19   was informed by individual clinicians who were taking  
20   care of people who were smoking or having angina.

21          Q.    Sure.  I understand that most of the  
22   conclusions in the '83 report were based on  
23   epidemiology.  But talking about the epidemiology of  
24   angina as it relates to smoking, there was at least a  
25   question about that in the mind of the Surgeon General

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1 in '83?

2 A. You would have to ask the Surgeon General --

3 Q. Okay. Let me just ask you --

4 A. -- what questions were in his mind.

5 Q. Okay. Let's look at page -- I asked if you  
6 recall -- Page 102. Actually, let me ask you if you  
7 recall hearing this in your deposition, quoting from  
8 Page 102, on Page 87 --

9 MR. ROSENBLATT: Wait. You're on --

10 MR. REID: Page 87 of the deposition, which  
11 was quoting from Page 102 of the Surgeon General's  
12 Report:

13 In addition to the excess risk of non-failed  
14 myocardial infarction and death from coronary heart  
15 disease, sudden cardiac death in women has been  
16 observed to be strongly related to the cigarette  
17 smoking habit; however the relationship of angina  
18 pectoris to cigarette smoking is uncertain. As in men,  
19 some studies have shown a positive relationship with  
20 smoking, but others have found no significant  
21 difference in the occurrence of angina between female  
22 smokers and nonsmokers.

23 Do you recall reading that at some time?

24 A. Yes.

25 Q. Let me ask you about another subject, and

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1       that is, you've heard the word "multifactorial" used --

2           A.    Yes.

3           Q.    -- with regard to heart diseases?

4           A.    Yes.

5           Q.    What does it mean in that context?

6           A.    I would say that when people talk about  
7       multifactorial causes, they are talking about  
8       individuals where there are more than one factor  
9       present that could have caused the coronary heart  
10      disease.

11          Q.    And coronary heart disease has been described  
12      as a multifactorial disease, has it not?

13          A.    Yes.  That's correct.

14          Q.    And that means that there are a number of  
15      risk factors which have been associated with coronary  
16      artery disease or heart disease in general?

17          A.    It means there are a number of factors that  
18      tend to be -- to be additive, so that if you smoke, you  
19      have an increased risk three-fold.  If you smoke and  
20      you are a diabetic, your risk is five-fold greater than  
21      not having either of those.

22                If you smoke and you're a diabetic and you  
23      have high cholesterol, your risk might be eight-fold  
24      above that of someone who had none of those things.

25                So that is what is meant by multifactorial,

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1 at least to me. That's what I would mean by it.

2 Q. And there are risk factors that are  
3 considered to be independent risk factors, aren't  
4 there?

5 A. Yes.

6 Q. Have you ever read that there are as many as  
7 230 or 240 risk factors associated with heart disease?

8 A. I don't think I've ever read that there are  
9 that many. I think that maybe six or seven factors.

10 Q. Well, I want to ask you about some of these.  
11 You mentioned cholesterol today. Is cholesterol --

12 A. Definitely.

13 Q. -- or high cholesterol a risk factor?

14 A. High cholesterol is certainly a factor that  
15 can cause coronary heart disease.

16 I'm trying to avoid the term "risk factor"  
17 only because I know that it can be confusing and to  
18 many people it implies, well, you're at a risk, but  
19 maybe it didn't cause it.

20 To me it's a factor, and in some people it's  
21 causative, and in some people it's not causative.

22 Q. Are you familiar with the Seven Country  
23 Study?

24 A. I've read that, but not recently.

25 Q. And did that find that even among smokers,

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1       when the cholesterol levels were low, that there was a  
2       low incidence of heart disease?

3           A.    Do you have the study?

4           Q.    No.   I don't have the study.

5           A.    I'd be happy to refresh my memory.

6           Q.    No.   I don't have it with me.   I'm asking you  
7       if you recall it.

8           A.    I don't recall enough about the study, but it  
9       certainly could have said that.   It sounds like a  
10      reasonable type of conclusion from an epidemiologic  
11      study.

12          Q.    If we focus on artery, coronary artery  
13      disease, heart disease, it's true, isn't it, that if a  
14      person gets cholesterol low enough, that this person  
15      could smoke without regard to any risk associated with  
16      the coronary arteries; is that correct?

17          A.    Well, I don't know that, but I wouldn't be  
18      surprised if that were operative in some of these  
19      patients that we refer to.   I did say earlier that  
20      there were definitely people, I've seen them, who were  
21      able to smoke until they're 90 without having problems.

22                So it might well be that the reason that they  
23      could get away with it is that their cholesterol was  
24      incredibly low.   I don't know that that's been  
25      carefully studied.

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1 Q. That's something else, going back to your  
2 three levels of research, the scientific methods,  
3 something that scientists are looking at, I assume?

4 A. Yes.

5 Q. What about family history, is that a risk  
6 factor?

7 A. Definitely.

8 Q. I'm trying to write these down so we can  
9 remember.

10 How about hypertension?

11 A. Definitely.

12 Q. And tell the jury what hypertension is.

13 A. High blood pressure.

14 Q. Okay. And homocystine?

15 A. Homocystine.

16 Q. I never know whether it's E or I.

17 Tell the jury what that is.

18 A. Homocystine is an amino acid that is normally  
19 present in the blood. It's present in everyone. You  
20 need to have some homocystine in order to develop  
21 normally. But if it's present in excessive amounts, it  
22 can damage the lining of the coronary arteries and  
23 other arteries and can lead to atherosclerosis.

24 Q. That's a risk factor for heart disease?

25 A. Yes.

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1 Q. What about obesity?

2 A. It's not clear whether obesity is a separate  
3 risk factor or whether it acts through some of these  
4 other factors. It probably has a very low level of  
5 risk of being an additional factor, but I believe  
6 there's still uncertainties on that point because most  
7 obese folks have increased diabetes, they have a higher  
8 incidence of high blood pressure, their cholesterol  
9 tends to be higher, so it's hard to find obese  
10 individuals who have normal cholesterol, no diabetes,  
11 no high blood pressure, et cetera.

12 Q. Are you familiar with the position taken by  
13 the American Heart Association regarding obesity as an  
14 independent risk factor?

15 A. I think they believe it is an independent  
16 risk factor, but that may be one area where the  
17 American Heart Association could be treading on a  
18 little thin ice. I would never want to imply that  
19 because something is stated by the American Heart  
20 Association, it's gospel, and 50 years from now we look  
21 back and say: Gee, wasn't the American Heart  
22 Association brilliant?

23 We're learning new things every day. I can  
24 only tell you what I think I know today.

25 Q. Sure. So, well, I guess what you're telling

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1 me is notwithstanding that they have identified it as a  
2 separate independent risk factor, your thought is that  
3 there may not be quite enough research to reach that  
4 conclusion yet?

5 A. That's my opinion.

6 Q. But you would expect the American Heart  
7 Association as having an interest in public health  
8 perhaps to move ahead of the research, so to speak?

9 A. I think from a population standpoint, people  
10 should try to keep their weight down because if -- you  
11 would be very lucky if you didn't have any genes from  
12 your background for diabetes, high blood pressure, high  
13 cholesterol, et cetera, and if you have some of these  
14 things and you put on an excessive amount of weight,  
15 you're likely to at that point bring out the condition.  
16 You may bring diabetes on or some other condition.

17 So, yes, I don't tell my patients they should  
18 just sort of eat whatever they want, and I don't care  
19 whether they're overweight or not.

20 Q. Well, my question was, it doesn't surprise  
21 you that the American Heart Association would be taking  
22 the position before all of the scientific research had  
23 been completed?

24 A. Yes. It wouldn't surprise me, that's  
25 correct.

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1           Q.    That's because their interest is public  
2    health?  
3           A.    That's correct.  
4           Q.    And age is a risk factor for --  
5           A.    Yes.  
6           Q.    And gender would be a risk factor?  
7           A.    It's not clear anymore that gender is a risk  
8    factor. Gender is definitely a risk factor before  
9    menopause. But after menopause I don't think you could  
10   say that.  
11          Q.    Okay. Now, there is something called LPA,  
12   LP(a).  
13          A.    It's a form of cholesterol, yes.  
14          Q.    Is that a separate risk factor from the  
15   cholesterol risk factor that has only recently been  
16   considered?  
17          A.    When I say that cholesterol is a risk factor  
18   for atherosclerosis, but that I mean that abnormalities  
19   of the lipids or fats in your blood -- and there are a  
20   number of different ones that would fall into this high  
21   LDL, low HDL, or the good cholesterol, elevations in  
22   LP(a), yes, there are a number that are risk factors.  
23   But they all fall under the category of what's called  
24   hyper -- the technical name for this is hyperlipidemia,  
25   which people in common parlance talk about as high

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1 cholesterol.

2 Q. I'm going to put LP(a) on my list up here  
3 next to cholesterol.

4 A. Sure.

5 Q. What about a sedentary lifestyle, is that a  
6 risk factor for heart disease?

7 A. It's listed by many as a risk factor. Again,  
8 I'm not sure that it's acting independent of these  
9 other factors. People who exercise regularly tend to  
10 have a lower weight, they have less hypertension, they  
11 have -- their diabetes is under better control. They  
12 may never develop diabetes. So exercise -- I exercise  
13 myself and recommend it to my patients. But I'm not  
14 sure that a sedentary lifestyle, in and of itself, if  
15 you had none of the other things, would be bad for you.

16 Q. But it's certainly accepted as a risk factor  
17 by a number of people who list risk factors?

18 A. Yes.

19 Q. Doctor, we were going through a list of risk  
20 factors identified by you and others associated with  
21 heart disease, and I wanted to ask you if in fact what  
22 has been called, I guess popularly called the type A  
23 personality, is that a risk factor for heart disease?

24 A. I think that probably is. Whether it's  
25 independent of some of these other things, I don't

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1 know. But the data do suggest that people, such as  
2 myself who have a type A personality, are at an  
3 increased risk of coronary heart disease.

4 Q. What about disorders of blood coagulation?  
5 That's considered a risk factor?

6 A. There are -- the evidence is weaker here, but  
7 I would say that's certainly high on the list of  
8 potential candidates. I think the top ones you have on  
9 the list are the proven ones.

10 Q. Sure. I understand.

11 A. But the blood coagulation factors are  
12 increasingly looking like risk factors, or factors.

13 Q. What about emotional stress?

14 A. Yes. No question about it in my mind in  
15 individual patients. You won't see this in  
16 epidemiologic studies very often, because it's so hard  
17 to measure emotional stress.

18 You certainly don't see this very well  
19 studied in animal studies. But in individual patients,  
20 as I mentioned earlier, I'm convinced that individual  
21 patients' emotional stress can precipitate a heart  
22 attack.

23 Q. And what about alcohol?

24 A. Alcohol is not a risk factor for coronary  
25 heart disease, to my knowledge.

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1 Q. How about coffee?

2 A. I don't believe coffee is a risk factor.

3 There have been conflicting studies on this. But my  
4 reading of the data is that coffee is not a risk factor  
5 for coronary heart disease. It could be a risk factor  
6 for a rhythm disturbance in a susceptible individual,  
7 but that's a different kind of heart disease.

8 Q. And what about infection? Like there's been  
9 some research recently that infection may have  
10 something to do with heart disease; is that fair to  
11 say?

12 A. Yes. It's a hot topic that certain bacteria  
13 like chlamydia are now being looked at to determine  
14 whether they can cause a heart attack. A lot of this  
15 interest has been spurred by the discovery of a  
16 bacteria as a cause for duodenal ulcer disease. But I  
17 think the evidence so far is pretty weak.

18 In fact, there have been some studies where  
19 patients have been randomized to antibiotic versus no  
20 antibiotic to see whether the antibiotic could prevent  
21 a heart attack, and the data on those studies is not  
22 very impressive.

23 Q. Can you think of any others that I've left  
24 out?

25 A. Not at the moment.

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1           Q.    You've said smoking.  I mean, I should add  
2   smoking because you said that?

3           A.    Well, that's number one on my list.  But you  
4   are making your own list right there.  That's true.

5           Q.    Would you agree that science has probably not  
6   discovered all the risk factors yet for heart disease?

7           A.    Yes.

8           Q.    And that's the reason we go through the three  
9   levels of investigation that we talked about?

10          A.    Yes.

11          Q.    Now, are there -- changing the subject a  
12   little bit, there are some heart-related diseases that  
13   have no relationship to smoking; is that true?

14          A.    That seems to be the case, yes.

15          Q.    And endocarditis would be one such thing?

16          A.    Yes.  Bacterial endocarditis, to my  
17   knowledge, has no relation to cigarette smoking.

18          Q.    And valvular heart defects?

19          A.    Certain valvular heart defects are congenital  
20   and clearly have no relation to cigarette smoke.

21          Q.    And there are some diseases that are related  
22   to the integrity of the heart muscle.  Those haven't  
23   been associated --

24          A.    Some cardiomyopathies don't seem to be  
25   related to cigarette smoking.

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1           Q.    And what about metabolic disturbances in the  
2    heart, improper levels of calcium, potassium,  
3    magnesium, things such as that, would any of those be  
4    related to smoking?

5           A.    I don't know that that's been studied  
6    specifically.

7           Q.    And what about tumors originating in the  
8    heart? Those have not been associated with smoking,  
9    have they?

10          A.    Tumors are extremely rare in the heart, as  
11    you probably know, and I can't say I've seen more than  
12    a handful in the course of my career.

13          Q.    No one has suggested that smoking has  
14    anything --

15          A.    I never read a suggestion that they're caused  
16    by cigarette smoking.

17          Q.    When you're working with a patient who has an  
18    artery problem and has plaque that you described, you  
19    can't tell what caused that plaque to get there, can  
20    you?

21          A.    Not by looking at the plaque, no.

22          Q.    And if you studied it under a microscope, you  
23    wouldn't be able to determine whether it came from a  
24    smoker or from a nonsmoker, would you?

25          A.    No.

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1           Q.    And if you didn't have any medical history  
2    about a patient, you wouldn't be able to tell from the  
3    appearance of the arteries whether this person smoked  
4    or didn't smoke, would you?

5           A.    I wouldn't, but I'm not sure whether a  
6    pathologist or someone more qualified than that could  
7    tell the difference, but I certainly wouldn't.

8           Q.    And it's fair to say that the vast majority  
9    of people who smoke do not get heart disease in any  
10   form, isn't it?

11          A.    Well, I really wouldn't know about that. I'm  
12   not familiar with any studies that have been done.  
13   That would be a good study. The tobacco companies  
14   could actually look at all the people they sell  
15   cigarettes to and see what happens to them.

16          Q.    So as you sit here today, you don't know  
17   whether or not a large percentage of smokers get heart  
18   disease or a small percentage of smokers get heart  
19   disease?

20          A.    I can't give you any numbers on that, no. I  
21   see it from a different point of view. I see people  
22   who come in with a heart disease. So I'm not -- you  
23   know, as a physician, I don't see the patients who  
24   don't have disease. I can't really comment on how many  
25   of them there may be. But when patients come in with a

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1 heart attack, that's when I get to see them.

2 Q. And you never read anything on or heard  
3 anything at any meetings that would allow you to answer  
4 the question that I just asked?

5 A. I can't recall anything at this time that --

6 Q. Okay.

7 A. -- that relates to that question.

8 Q. Would you agree that 50 percent of the people  
9 with coronary artery disease have no established risk  
10 factor at all?

11 A. I've seen that number. I would say from my  
12 own experience that number always seemed a little high,  
13 and maybe the nature of my practice -- I would say in  
14 probably 70 or 80 percent of the people that I see, a  
15 particular factor can be identified that I believe was  
16 causative in their case.

17 Q. So I think you actually told us in your  
18 deposition it would be closer to 5 percent have no  
19 identifiable risk factor. You think it may be --

20 A. Yeah, it's low. I think -- I guess what I  
21 would say is the majority of patients that I see when I  
22 go over things in great detail -- and I think that's --  
23 that may be part of it, it's how hard you look. The  
24 majority of them I can find something that I believe  
25 was causative in their case.

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1                   Now, if I said only 5 percent were, and now  
2       I'm saying 20 to 30 percent, you know, that's what I'm  
3       seeing. It's a guess, because I haven't made any  
4       statistical study of it in my own practice.

5           Q.    Are you familiar with Dr. Eugene Braunwald?

6           A.    Yes.

7           Q.    And he is a noted authority in your field?

8           A.    Yes.

9           Q.    And you told us that the New England Journal  
10       of Medicine was an important publication in your field?

11          A.    Yes.

12          Q.    Let me show you an article that appeared, and  
13       if you turn over to Page 1364, and I'm now still  
14       talking about the subject matter of how many people who  
15       have heart attacks do not have risk factors.

16                   On the second column under "inadequate  
17       knowledge," I'll read this to you:

18                   Although much has been learned about the  
19       causes of coronary heart disease, the gaps in knowledge  
20       are noteworthy. For example, fully half of all  
21       patients with this condition do not have any of the  
22       established coronary risk factors: hypertension,  
23       hypercholesterolemia, cigarette smoking, diabetes  
24       mellitus, marked obesity and physical inactivity.

25                   Do you see what I'm reading?

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1           A.    Right.

2           Q.    Okay.  So is it fair to say that from the  
3   view of Dr. Braunwald, that as of now science has been  
4   unable to discover the risk factors associated with 50  
5   percent of the coronary artery disease that exists in  
6   the world?

7           A.    I would say that certainly you read his quote  
8   exactly, and that's obviously what he believed at the  
9   time that he wrote that.

10                  I think his article, because I remember this  
11   article, was based primarily on epidemiologic studies,  
12   not completely but primarily.  And from that point of  
13   view, that would have to be correct.

14                  I will say that I worked for Dr. Braunwald  
15   for a good many years, and he's one of the most  
16   brilliant men that I've ever met.  But he wasn't always  
17   right.

18           Q.    You've made reference in your answer to  
19   Dr. Braunwald believing this when he wrote this.  It  
20   was written in November of 1997.

21           A.    Right.

22           Q.    Is that correct?

23           A.    That's what Dr. Braunwald states in this  
24   article, correct.

25                  MR. REID:  I want to mark as Exhibit A,

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1 Doctor -- no. I'm actually not going to mark it now.  
2 We'll take all of that later. Go ahead, sir. That's  
3 all I have.

4 MR. ROSENBLATT: My turn again.

5 REDIRECT EXAMINATION

6 BY MR. ROSENBLATT:

7 Q. Dr. Grossman, let me pick up where counsel  
8 left off.

9 Dr. Braunwald, what did you say, you worked  
10 under him?

11 A. Yes. I worked for Dr. Braunwald for many  
12 years.

13 Q. In what capacity?

14 A. Well, he was the chief of medicine at the  
15 Brigham -- at Harvard in 1975, and he recruited me to  
16 come back to Harvard from North Carolina to run the  
17 cardiac cath lab. He then recruited me and offered me  
18 the position as chief of cardiology at the Beth Israel  
19 Hospital. So he was my direct supervisor for about 15  
20 years, and I worked with him very closely.

21 He is a brilliant man and one of the most  
22 respected authorities in the field of cardiology today.

23 Having said that, he wasn't always right, and  
24 I think he would be the first to admit that.

25 Q. Dr. Grossman, I also noticed in going through

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1     your CV, that you and Dr. Braunwald have coauthored a  
2     number of articles together.

3             A.     That's correct.

4             Q.     Cardiology is defined as what? By the way,  
5     just to make this distinction, as a cardiologist, you  
6     do not actually perform surgery?

7             A.     That's correct.

8             Q.     So if you had a patient and you made a  
9     determination that your recommendation was going to be  
10    open-heart surgery, coronary artery bypass surgery, you  
11    would refer that patient to a cardiac surgeon?

12            A.     Yes.

13            Q.     Okay. So how do you define the field of  
14    cardiology?

15            A.     Well, strictly speaking, cardiology refers to  
16    the study of diseases of the heart and the treatment of  
17    patients with heart disease.

18            As you noted, though, when you were going  
19    through my board certifications, the board actually is  
20    in cardiovascular diseases, and most of us, myself  
21    included, are specialists, not just in diseases of the  
22    heart, but in the vascular diseases, diseases of the  
23    blood vessels outside the heart, such as the aorta.

24            Q.     So when we talk about the human body's  
25    vascular system, we are talking about blood vessels all

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1 over the body, not just restricted to the heart?

2 A. Correct.

3 Q. And as chief of cardiology at the University  
4 of California and when you were chief of the  
5 cardiovascular division at Beth Israel Hospital  
6 connected with the Harvard Medical School, I assume you  
7 treated patients with all kinds of cardiac problems?

8 A. Yes.

9 Q. And I believe you described your hands-on  
10 cardiology practice as a diagnosis and treating as a  
11 general cardiology practice?

12 A. That's correct. My practice in the earlier  
13 years of my career was general with more of an emphasis  
14 on patients with heart failure and coronary disease,  
15 because I was doing cardiac catheterization.

16 In recent years I've had a much broader  
17 general population of patients, and that's partly  
18 because I see mainly patients now in consultation who  
19 have heard of me or their doctors know me and want me  
20 to see them for my opinion.

21 Q. Now, counsel mentioned that you were with a  
22 pharmaceutical company in your career, the Merck  
23 Pharmaceutical Company. They recruited you. But you  
24 worked for them for about how long?

25 A. Two and a half years, almost three years.

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1           Q.    And you went from there to your current  
2   position --

3           A.    Yes.

4           Q.    -- at the University of California?

5                    Okay.  Now, counsel made the point that  
6   whatever the percentage is or may be, there are some  
7   people who get heart disease without any discernible  
8   risk factors.  You would agree to that?

9           A.    Yes.

10          Q.    Okay.  And why that is, in speaking  
11   scientifically, is somewhat of a mystery, I suppose?

12          A.    Yes.  That's correct.

13          Q.    But the issue of whether cigarette smoking  
14   causes heart disease, is that a mystery?

15          A.    That's not a mystery to me.

16          Q.    I just want to have an understanding that not  
17   only in your present role, but when you were at the  
18   Harvard Medical School and throughout your career in  
19   academic medicine and with a specialty in cardiology,  
20   do you have occasion to interact constantly with  
21   cardiologists from all over the country and all over  
22   the world?

23          A.    Absolutely.  I do at all of these national  
24   meetings.  I'm often speaking and going.  I would say I  
25   give lectures maybe once a week at different hospitals

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1 in the Bay area. I did in Boston, and I give lectures  
2 throughout the country and internationally. And  
3 physicians are always coming up afterwards and having a  
4 chance to tell me about what they're doing.

5 And I don't recall ever having anybody come  
6 up and say to me: What do you think about smoking? Is  
7 that okay? Can we advise our patients to smoke? I  
8 mean, everyone knows. This is common knowledge in the  
9 medical, certainly in cardiology community, that  
10 cigarette smoking causes heart attacks.

11 Q. As a result of these meetings, as a result of  
12 interacting with your colleagues, how many  
13 board-certified cardiologists do you figure you know  
14 that you personally have spoken to in this country?  
15 You know, are we talking about -- how many, roughly?

16 A. Thousands.

17 Q. And by virtue of your writing articles, is it  
18 necessary, before you finalize an article that you  
19 write, that you check the research and publications of  
20 others in your field to make sure of the accuracy of  
21 your own statements?

22 A. Yes.

23 Q. Now, on Page 79 of your deposition, where  
24 counsel asked you a question, but I don't believe he  
25 read the complete answer, and I want to read the

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1 complete answer.

2 But just to put this in context -- and your  
3 deposition was taken May 1st of 1998 at your office in  
4 San Francisco?

5 A. In a legal office in San Francisco, downtown.

6 Q. Okay. I was not -- I was not personally  
7 there, but an associate of mine from my office was  
8 there, and then of course there was a lawyer  
9 representing one or more of the tobacco interests who  
10 was questioning you.

11 Now, Page 79 of your deposition:

12 Question: Would it make any difference in  
13 your opinion that cigarette smoking had been shown to  
14 cause cardiovascular disease if you were satisfied that  
15 cigarette smoke had never been shown to cause  
16 atherosclerosis in animals?

17 Answer: It probably would have some  
18 influence, but, again, I would like to state that this  
19 has not been an area of special expertise or research  
20 expertise of mine, and my conclusions have been based  
21 largely on my own clinical experience with patients,  
22 thousands of patients, who have come through the  
23 cardiac cath, catheterization laboratories of the  
24 hospitals I have worked at who had coronary artery  
25 disease. That's my primary basis for my conclusion

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1       that coronary artery disease can be caused by cigarette  
2       smoke.

3               My belief has been bolstered by reading of  
4       the epidemiological literature, the autopsy data, and  
5       the experimental literature.

6               Now, you mentioned thousands of patients.  
7       You meant that literally?

8               A.    Yes.

9               Q.    I'm looking for another part of the  
10       deposition that counsel asked you about.

11               Well, now, you gave an example earlier about  
12       this woman in an emergency room who had a sudden heart  
13       attack and died; and although you had no information  
14       from animal models, it was 100 percent clear to you  
15       what the cause of her heart attack was; is that  
16       correct?

17               A.    Yes.

18               Q.    Well, let me ask you -- let me ask you this  
19       question.

20               Is that really scientific? We hear about  
21       mechanism and we hear about animal models and we hear  
22       about the various criteria.

23               You walk in. You see she hasn't been a  
24       patient of yours. You don't have a detailed history,  
25       and the woman's obviously -- you make a diagnosis,

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1 she's had a heart attack and unfortunately she dies.

2 Is it really scientific? Do you feel  
3 comfortable reaching a scientific conclusion that the  
4 cause of that lady's heart attack was the stress of --  
5 what was it -- her husband or a close relative, who was  
6 in the emergency room and ill?

7 A. I don't have any doubt that that woman's  
8 heart attack was caused by the stress of what was  
9 happening to her husband.

10 Now, you asked whether I can draw a  
11 scientific conclusion about that. The science of  
12 medicine is partly based on data from large trials,  
13 epidemiological studies. It's partly based on animal  
14 studies, it's partly based on pathology studies, but  
15 it's also partly based on clinical experience and  
16 common sense.

17 There are many times when we just don't have  
18 the final answers in terms of hard animal experimental  
19 data, and I certainly will never go to a physician  
20 myself who waits for all that to be answered, because  
21 we have to make judgments, scientific judgments, based  
22 on our totality of knowledge.

23 Now, I know that emotional stress can cause  
24 constriction of arteries. It can cause blood pressure  
25 to go up. And this was not the only patient I know of.

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1 This was my patient where this happened, but certainly  
2 not the only patient I know of where severe emotional  
3 stress led to a fatal heart attack.

4 That was an unusual incident and a tragic  
5 one. But the incident of a patient having a heart  
6 attack, where there had been a heavy smoking history  
7 and no other identifiable risk factors, at least  
8 identifiable to me, that's not been a rare experience  
9 in my personal practice, and it's one I've seen on  
10 numerous occasions.

11 Q. Have you treated many patients where you were  
12 satisfied that absent the smoking, that there would  
13 have been no heart disease, there would have been no  
14 heart attack?

15 A. Yes. I have treated many such patients.

16 Q. Counsel seems to say: Gee, there is a lot of  
17 science missing. So I want to know why all you  
18 scientists appear perfectly comfortable in using the  
19 concept of causation.

20 A. I think the preponderance of the evidence is  
21 overwhelming. There is no question in my mind, and to  
22 the best of my knowledge in the minds of virtually  
23 every thought leader in cardiology in the world today,  
24 but certainly in the United States, because I know many  
25 of these individuals and have served on committees with

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1       them, that cigarette smoking is a direct cause of  
2       atherosclerotic rupture, myocardial infarction, heart  
3       attack, coronary death -- you can phrase it any way you  
4       want, but it's the same basic process. And the data  
5       are from many sources, epidemiologic, some animal  
6       experiment, and a good deal from clinical experience,  
7       and it's overwhelming. There is no question about it.  
8       I don't think this is open for debate.

9               Q.     Thank you, Dr. Grossman.  
10                    (The videotape concluded.)

11                   THE COURT:   Okay, folks. That ends the  
12       testimony of Dr. Grossman.

13                   Let's meet for a minute with the lawyers, and  
14       I will be able to tell you more about our schedule.

15                   (The following proceedings were had at  
16       sidebar:)

17                   MR. HEIM:   Let me just tell you what I wanted  
18       you to know, Judge. That is that I'm expecting that  
19       it's likely that over this weekend, probably on Sunday,  
20       there will be an announcement by a number of attorney  
21       generals -- I don't know how many, but it is a large  
22       number -- that there has been a settlement with four  
23       tobacco companies of the attorney general litigation.

24                   I don't believe that's all of the attorney  
25       general cases, but I believe that it will be an

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1 announcement that a certain number have agreed to  
2 settle, and that several others have until later in the  
3 month to make a decision on whether to do that or not.

4 MR. ROSENBLATT: Including the state of  
5 Washington case which was in trial now.

6 MR. HEIM: I believe so. And I was on the  
7 phone this afternoon to see whether that was in fact  
8 the case. I am told that there are some last-minute  
9 details, and it's possible it won't happen, too. But  
10 the more likely possibility is that it will.

11 And my suggestion to the Court is that we not  
12 make a big deal of it, but that Your Honor simply  
13 provide the jury with maybe a little more emphasis on  
14 the instruction that they ought to stay away from  
15 newspaper coverage, TV, articles, other sources of  
16 information or people who want to talk to them about  
17 the case; and that if they are exposed to any such  
18 conversations by others or if they do see these things,  
19 that they ought to bring it to your attention.

20 THE COURT: Well, we had something in the  
21 paper the other today about the Washington case, and I  
22 questioned them whether they had seen it, and they said  
23 no.

24 MS. LUTHER: There was an article about LeBow  
25 on Tuesday.

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1           THE COURT: Nobody seemed to indicate  
2 anything about it. So I don't know.

3           But this one, if we can expect something over  
4 the weekend, we should caution them, since it is the  
5 weekend and we don't know what's going to happen. We  
6 don't know if there's going to be any publicity about  
7 anything.

8           MR. HEIM: I was going to do it on Friday.

9           MR. ROSENBLATT: We're not going to be here.  
10 We're on the cutting edge, Judge.

11          THE COURT: Cutting edge of what?  
12 Everybody's out but you.

13          MR. ROSENBLATT: We're going to be the only  
14 game in town, in the world.

15          MR. HEIM: Your Honor, I have to ask the  
16 company. I know if this happens on Sunday, they will  
17 be barraged with press requests, analysts and all the  
18 others. I have asked them to avoid mentioning this  
19 case, to just make generic statements if they possibly  
20 can.

21          THE COURT: Do you know of any other case  
22 other than attorney general cases that are involved?

23          MR. HEIM: No. I learned today that the  
24 Barnes case in Pennsylvania, the decertification, that  
25 summary judgment in favor of the defendants was

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1       affirmed by the Third Circuit. So that's not a  
2       problem, I'm happy to announce.

3               MR. REID: Also, the Fourth Circuit denied  
4       rehearing the case, deciding that the FDA could not  
5       regulate tobacco. That was decided.

6               THE COURT: Could not do what?

7               MR. REID: Could not regulate tobacco. Food  
8       and Drug Administration. We discussed that through a  
9       document a few weeks ago. That's happened just the  
10      last day or so I think.

11              MR. HEIM: The short answer, Judge, is I  
12      don't know of any other case.

13              MR. ROSENBLATT: But the Third District Court  
14      of Appeal has not been reversed in either Broin or  
15      Engle.

16              THE COURT: Yet.

17              MR. ROSENBLATT: No, never. No one to  
18      reverse them. The Florida Supreme Court had an  
19      opportunity.

20              THE COURT: The only problem is we've got  
21      briefs going up, right?

22              MR. ROSENBLATT: Oh, but that wouldn't --  
23      that's something else, not decertification.

24              THE COURT: I mean, let's face it, they had a  
25      case here, a judge on a matter, an election matter.

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1       Made a ruling concerning election. The Third said:

2       The heck with it. We'll reverse everything.

3               MR. HEIM: Well, you know as much as I do,  
4       Judge.

5               THE COURT: Okay. The issue of telling them  
6       about the preemption matter, that's something that  
7       concerned me on the basis -- Mr. Moss isn't here, but  
8       on the basis of the timeliness of the instruction. We  
9       sort of agreed that we were going to hold off on it,  
10      but I'm more inclined to go ahead and say something  
11      about it, because it will come up again.

12              MR. HEIM: Okay.

13              THE COURT: I don't think it's going to be  
14      anything detrimental.

15              So I don't know when to say it, whether -- I  
16      don't know if I ought to say anything now. They will  
17      probably forget it over the weekend.

18              MR. ROSENBLATT: Yes. I would like an  
19      opportunity to talk to Susan about it, see what's been  
20      going on.

21              MR. HEIM: Well, that's okay with me, Judge.  
22      We will have some free time tomorrow. Maybe we can all  
23      talk about it tomorrow and you can mention it on  
24      Monday.

25              THE COURT: Let's do that.

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1 MS. LUTHER: While we're here, I spoke with  
2 Mr. Rosenblatt earlier and he indicated he have wasn't  
3 planning on doing any Liggett depositions or documents,  
4 so with your permission I will not be here tomorrow.

5 THE COURT: You've got to be here and suffer  
6 with us.

7 MR. ROSENBLATT: I could be wrong, Kelly.

8 MR. NEWSOM: Mr. Martinez asked you that I  
9 remind you that he's not going to be here. So there  
10 won't be any TI documents or depositions.

11 MR. ROSENBLATT: Do you know where Martinez  
12 is going to be? Wherever the University of Miami is at  
13 a football game. Probably an audience of 12.

14 MR. HEIM: They have a good team.

15 THE COURT: I would like to know what he  
16 sounds like.

17 MR. ROSENBLATT: Sounds good. I don't  
18 understand him, but he sounds good.

19 MS. LUTHER: I'm assuming you were joking.

20 THE COURT: About what? About you? Yes.

21 MS. LUTHER: I want to be clear.

22 (The sidebar conference was concluded, and  
23 the following proceedings were held in open court:)

24 THE COURT: Okay. Trying to work out our  
25 schedule and all of that. We will break now. It's

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1 five or ten minutes after. We will see you folks on  
2 Monday.

3 As we get into this case deeper and deeper  
4 and deeper, it becomes much more important that you  
5 folks strictly adhere to the rules the Court has laid  
6 down regarding your own personal investigation on any  
7 of these issues, because I know you're curious, and  
8 conversations you may have with people, especially  
9 people that know you're on the jury, who want to know,  
10 after all this time, what's going on, all that. So you  
11 must not discuss it with them.

12 And it also applies to anything that may  
13 appear in newspapers, radio, television, anything of  
14 that nature. Very scrupulously avoid listening to  
15 anything, hearing anything or reading anything that may  
16 relate to this case or any other tobacco-related  
17 issues.

18 Okay? We really have to -- after spending  
19 all this time, we don't want anybody to come in and get  
20 anything from the outside that is going to affect them  
21 here. You never know. Who knows what's going to  
22 happen?

23 So I want to caution you again, because I  
24 haven't talked to you about that for a while, to be  
25 very careful what you're exposed over the weekend or

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1 any time you're not here, regarding the tobacco issues.

2 Okay?

3 All right, folks. Have a wonderful weekend.

4 We'll see you on Monday. Usual time, 9:15.

5 (The jurors exited the courtroom.)

6 THE COURT: Okay. So we will see you folks  
7 tomorrow, I take it.

8 MR. ROSENBLATT: Now, the question is, Judge,  
9 do you want any more depositions? I'm not offering to  
10 give you work, but --

11 THE COURT: Well, I just went through this  
12 tome here, which was Spears, while Grossman was on.

13 I haven't decided -- I put a lot of question  
14 marks, because there are a lot of areas in there.  
15 There are some, for example, that relate to secondhand  
16 smoke and banning in restaurants, and there was a lot  
17 of stuff similar to what had happened in the previous,  
18 in the Broin deposition. Then there were a lot of  
19 things that didn't seem to relate to this particular  
20 case.

21 MR. ROSENBLATT: I've been told -- I tried to  
22 get a sounding from the defense attorneys as to whether  
23 they're going to bring in any CEOs. No one has stated  
24 anything directly. But my feeling is that most likely,  
25 if they decide on a CEO, probably the most likely one

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1       they will bring in is Spears. So in my mind, he's  
2       someone down on my list of someone I have to read  
3       quickly.

4               THE COURT: I'm glad you told me that.

5               MR. ROSENBLATT: Always that way.

6               MR. HEIM: Your Honor, we're not being coy  
7       about it. I think you make a decision about that as  
8       you get further into the case and see where the  
9       plaintiffs are with their evidence.

10              THE COURT: You're entitled to that, and I  
11       expect that. But on the other hand, if you're going to  
12       bring somebody in live, I think they ought to know  
13       about it in advance,

14              MR. HEIM: We're certainly going to tell  
15       them.

16              MR. NEWSOM: Does that mean we're not going  
17       to discuss Spears tomorrow?

18              MR. ROSENBLATT: No. My preference would  
19       have been Campbell, Johnson, Johnston.

20              THE COURT: Okay. One of the Johnsons I'm  
21       going to have to review tonight.

22              MR. ROSENBLATT: Do you want any of that now?  
23       Have you read Campbell?

24              THE COURT: I read Campbell and one of the  
25       Johnsons.

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1                   MR. ROSENBLATT: I think the one from  
2   American Tobacco.

3                   MR. HEIM: Donald.

4                   MR. ROSENBLATT: Some you can do as we go  
5   along.

6                   THE COURT: So we will take up those  
7   questions tomorrow. Leave Spears off.

8                   MR. ROSENBLATT: So tomorrow, from my  
9   standpoint, is not going to be a document day, but a  
10   deposition today. Particularly because I've got  
11   witnesses for Monday and Tuesday, but I don't for  
12   Wednesday and Thursday. You know, I'll check with the  
13   office and if we can get a live witness for Wednesday  
14   or Thursday, I will.

15                  THE COURT: Okay.

16                  MS. LUTHER: Tuesday's witness, Stanley?

17                  MR. ROSENBLATT: Farone, he will be here  
18   Monday afternoon, if Dr. Douglas finishes early.

19                  THE COURT: 9:30.

20                  MR. SCHNEIDER: Judge, you have two Johnsons  
21   and Campbell.

22                  THE COURT: I believe I do have the --

23                  MR. SCHNEIDER: Donald Johnson is the  
24   president of American Tobacco. You have that one for  
25   sure.

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1 THE COURT: Yes.

2 MR. SCHNEIDER: And then Campbell I think you  
3 have.

4 THE COURT: I know I did Campbell. It's just  
5 a question of the other Johnson.

6 MR. SCHNEIDER: That will be the one the  
7 parties will be prepared to address tomorrow.

8 THE COURT: I'll tell you, if I have not gone  
9 over the other Johnson, whatever his first name is, we  
10 can do it while we're here. Not really that big a  
11 deal. Okay.

12 (Court was adjourned at 5:15 p.m.)

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